

VAHSI Independent Evaluation

Evaluation Report

FINAL

Date: 1 April 2025

Executive Summary

Introduction and Background

The Vaccine Access and Health Security Initiative (VAHSI) was established to support equitable and inclusive access to COVID-19 vaccines in the Indo-Pacific region, tailored to country need and supported by Australian technical expertise (October 2020 – December 2024).

In 2020 and 2021, the focus of the initiative was procuring and supplying COVID-19 vaccines to countries. In 2022, VAHSI's scope was expanded to include routine and catch-up immunisation for other vaccine-preventable diseases (VPDs). In that year, the initiative continued to supply vaccines to countries, and also provided delivery support for immunisation activities, and moved programming from an initial rapid response phase to a longer-term response phase. In 2023 and 2024, VAHSI focused solely on providing delivery support for immunisation activities in-country.

Table 1: Detail of investment in scope for this evaluation

Investment	Period	Funding (AUD in millions)
VAHSI	FY20-21 to FY24-25	523.2
Australia's contribution to the Quad Vaccine Partnership	FY21-22	100.0
Bilateral funding contributed to VAHSI delivery support agreement and vaccine procurement (Vietnam)	FY20-21 to FY22-23	18.2
Bilateral funding contributed to VAHSI delivery support agreement (Laos)	FY20-21	1.0
Total Funding	FY20-25	642.4

The three components of VAHSI are:

1. **COVID-19 vaccine access:** delivery of doses from Australia's domestic supply and through regional procurement arrangements with UNICEF. In Southeast Asia (SEA) this was supplemented by funding committed as part of Australia's contribution to the Quad Vaccine Partnership.
2. **In-country delivery support:** Tailored assistance to partner countries' national COVID-19 vaccination programs, including technical advice to national regulators, support for public communication campaigns, cold chain infrastructure, and other logistics capacity. In SEA this was supplemented by AUD24 million allocated as part of Australia's contribution to the Quad Vaccine Partnership.
3. **Regional health security architecture:** VAHSI allocated AUD21 million to establish an ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED) to help SEA prepare for and respond to future pandemics. The establishment of ACPHEED is being implemented separately and on a longer-term timeline than other VAHSI activities and is therefore not in scope for this review.

Recognising that structural inequality results in some communities being more vulnerable than others, the Australian Government Department of Foreign Affairs and Trade (DFAT) worked with delivery support partners to advocate for and support equitable and meaningful engagement with diverse stakeholders in planning and safely delivering vaccines and engaging diverse communities through inclusive communications. The end of program outcome for VAHSI reflected the prioritisation of the goal of *inclusive* recovery.

Evaluation design and methodology

The evaluation has been designed to assess the performance of VAHSI, including co-programmed support delivered as part of Australia's contribution to the Quad Vaccine Partnership and bilateral funding, where these contributed to COVID-19 vaccine access and delivery support activities (excluding ACPHEED establishment). The evaluation questions are:

1. **EQ1** - How did VAHSI contribute to safe, effective and accessible COVID-19 vaccine supply; and promote COVID-19 and routine immunisation coverage in line with partner country plans in the Indo-Pacific Region? (Effectiveness – EOPO1 and EOPO2)
2. **EQ2** - How did Australia's support contribute to stronger relationships between Australia and partner governments? Are there aspects of the support that have been more valued than others, and why? (Effectiveness – EOPO3)
3. **EQ3** - How has VAHSI made efficient use of Australia and partners' time, money and resources to achieve outputs and expected outcomes? Was the modality an appropriate mechanism to respond to regional and partner government needs? (Efficiency)
4. **EQ4** - To what extent was VAHSI effective in promoting and progressing gender equality and supporting disability equality and social inclusion processes and outcomes?
5. **EQ5** - What lessons can be identified that could inform design and implementation of future large-scale regional health emergency response programs, including on GEDSI? (Lessons for future programs)

The evaluation is both summative and formative in design to assess effectiveness and efficiency and to identify lessons for future programs, in particular in health emergencies.

A desk review of relevant documentation (including partner reporting) and key informant interviews were used to gather and collate evidence.

Findings

EQ1 – Effectiveness (EOPO1 & EOPO2)

EOPO1 – Partner governments expand COVID-19 vaccine coverage in a safe and timely manner

EOPO2 – Target populations access vaccination in accordance with each partner country's COVID-19 National Deployment and Vaccination Plan

There is substantial evidence of the effectiveness of VAHSI, both in terms of safe, effective and accessible COVID-19 vaccine supply, and in the promotion of COVID-19 and routine immunisation coverage in line with partner country plans in the Indo-Pacific region. End-of-program-outcomes (EOPOs) 1 and 2 are largely on track to be achieved. With 52,078,270 COVID-19 vaccine doses provided between March 2021 and May 2024, the COVID-19 vaccine supply effectively supported partner countries. VAHSI vaccine delivery support activities were generally performed effectively and

improved COVID-19 and routine immunisation coverage. An extensive quantity and diversity of end-to-end immunisation activities were undertaken, generally to expectations. These reached sub-nationally and to hard-to-reach populations, to a safe and high-quality standard, in a timely manner, and with flexibility in addressing the changing and complex operational realities of the COVID-19 pandemic. There were little to no reported unexpected outcomes, and the VAHSI investment has contributed to health systems strengthening in the countries assessed in this evaluation.

EQ2 – Effectiveness (EPO3)

EPO3 – Australian support to COVID-19 vaccination programs is valued by the region

Based on extensive interviews and review of documents, the evaluation found that VAHSI support contributed to stronger relationships between Australia and partner governments. This was particularly evident from qualitative data and KIIs. However, it is unclear whether this impact will be sustained over time and with changes of government. With some exceptions, the positive impact was likely stronger in the Pacific than Southeast Asia (SEA) due to difference in population sizes and therefore the relative importance of Australian support. Partner governments particularly valued the vaccines, but also the flexibility of the program and the partnership with Australia.

EQ3 - Efficiency

There is substantial evidence to demonstrate that the VAHSI program was an efficient use of Australian and partners' time, money and resources and that VAHSI was an appropriate mechanism to respond to regional and partner government needs. The comprehensiveness of Australia's response – vaccines, delivery support, technical expertise – was considered efficient and highly valued. A multilateral vaccine access mechanism existed, to which Australia contributed, but this mechanism was notably slower to support countries early in the response. There were some bureaucratic and staffing inefficiencies that could be improved upon for future responses.

EQ4 - GEDSI

Overall, evidence indicates that partners delivered GEDSI-sensitive programming. Almost all partners responded to partner government prioritisation of high-risk groups and hard-to-reach populations and applied knowledge of gender barriers to access to interventions. The picture for disability was more mixed, with some partners providing high priority focus on including and reaching people with disabilities and others not having the internal policies and processes to ensure that this occurred.

EQ5 – Lessons for future programs

The evaluation identified a range of lessons for future large-scale emergency response:

- **Bilateral relationships:** Strong bilateral health relationships and networks enabled faster deployment of resources and a level of trust that might not otherwise have existed.
- **Partnerships:** Established partnerships that could be leveraged from the outset were important in facilitating a rapid response. As well as delivery support partners, this included the role played by Australian expert research and health institutions in ensuring the sharing of best practice and knowledge.

- **Flexibility and responsiveness:** Flexibility in the response, with proposals tailored to country context, and allowing pivots as needed (e.g. to routine immunisation support) was vital to the success of VAHSI.
- **Processes:** Streamlined processes for approvals and clearances ensure resources can be allocated quickly and efficiently.
- **Resourcing and staffing:** In-country local knowledge, networks, contacts and expertise is vital for implementing large scale response programs such as VAHSI
- **Data and information:** It is essential to ensure timely data collection, reporting and accurate information on how a country is managing a pandemic, including national and sub-national immunisation and population data. Delivery support partners need to be informed of minimum data requirements at the outset and processes for collecting and analysing these data be made clear – and fit for purpose.
- **Partner selection (GEDSI):** There are significant benefits to delivery support partners working with NGOs on the ground that have pre-existing networks and relationships. Where these NGOs are existing DFAT partners (through the Australian NGO Cooperation Program or Australian Humanitarian Partnership) with an understanding of DFAT standards, attention to GEDSI can be amplified and expedited.
- **Role of Organisations of Persons with Disabilities (OPDs):** The clear and strong role of OPDs and the benefits of in-country partners having strong connections (and or formal agreements) with these organisations can allow for rapid access to data and provide mechanisms for accessing people with disability for consultation and broader inclusion in subsequent programming.

Recommendations:

The following recommendations highlight areas for DFAT consideration in future large-scale emergency health responses:

1. DFAT should implement a modality similar to VAHSI in future emergency situations for provision of vaccines (and potentially other emergency supplies), with emphasis on early bilateral support, as well as maintaining multilateral support.
2. DFAT should facilitate rapid funding approval processes for delivery support proposals during an emergency context.
3. During interpandemic periods, DFAT should continue to prioritise investment in immunisation support that will build capacities and strengthen bilateral relationships with country partners, as well as in-country and multi-country agencies.
4. DFAT should continue to advocate with partner governments for health systems strengthening that builds upon the VAHSI investment and positions countries for more resilience and preparedness for future emergencies.
5. Prior to the end of VAHSI, DFAT should facilitate a knowledge sharing event among VAHSI delivery support partners to share the most salient partner learnings from implementation of the VAHSI initiative in the Indo-Pacific region.

6. DFAT should ensure that future health emergency response mechanisms are designed to enable flexible deployment of support, resources and programmatic changes in response to changing partner country needs and priorities.
7. If not already in place, or under development, DFAT should consider establishing an emergency staffing plan to be able to respond quickly to staffing needs in a regional health emergency response.
8. DFAT should ensure the development and use of an MEL Plan for complex investments. In addition to a Performance Assessment Framework (PAF), DFAT investments should include an overarching MEL Plan to better articulate broader management of MEL including how different types of data are collected and how progress towards, and achievement of outcomes, are measured (and by whom). This should be communicated to delivery support partners up front in a MEL Guide that describes:
 - A. minimum data and reporting requirements
 - B. a process to ensure that these are understood and accepted by all funded delivery support partners, and
 - C. that systems are in place for ensuring quality/compliance with these requirements.Any changes in data or reporting requirements should be effectively communicated to partners. Where an overarching PAF is focused on End of Program Outcomes – the MEL Plan should include a description of ‘fit for purpose’ tools or processes (for example, Dashboards or streamlined Annual Reports) to better enable DFAT progress monitoring at the investment level.
9. In recognition of the significant value-add of OPDs to disability inclusion in these situations, DFAT should ensure ongoing support to OPDs, inclusive of supporting DFAT-funded delivery support partners to foster formal and long-term partnerships with OPDs. There may also be a role for DFAT and its delivery support partners to advocate for the inclusion of OPDs in ministry-level planning and coordination meetings.

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Acronyms

Acronym	Description
ACPHEED	ASEAN Centre for Public Health Emergencies and Emerging Diseases
AEFI	Adverse event following immunisation
AETAP	Australian Expert Technical Assistance Program
AHP	Australian Humanitarian Partnership
AIHSP	Australia Indonesia Health Security Partnership
ANCP	Australian NGO Cooperation Program
ASEAN	Association of Southeast Asian Nations
ATAGI	Australian Technical Advisory Group on Immunisation
COVAX	COVID-19 Vaccines Global Access
CHS	Centre for Health Security
DFAT	Australian Government Department of Foreign Affairs and Trade
EOPO	End-of-program outcome
GAVI	Gavi, the Vaccine Alliance
GEDSI	Gender, Disability and Social Inclusion
GHD	Global Health Division (DFAT)
GMP	Good Manufacturing Practice
HSI	Health Security Initiative
HSS	Health Systems Strengthening
IEC	Information, education and communication
IMR	Investment Monitoring Report
IO	Intermediate outcome
KII	Key Informant Interview
LES	Locally engaged staff
MEL	Monitoring, evaluation and learning
MELF	Monitoring, evaluation and learning framework
MOH	Ministry of Health
NCIRS	National Centre for Immunisation Research and Surveillance
NDVP	COVID-19 National Deployment Plans
NGO	Non-governmental organisation
NITAG	National Immunization Technical Advisory Group
OPD	Organisations of People with a Disability
PAF	Performance Assessment Framework
PHD	Partnership for Human Development
PSU	Program Support Unit
RCCE	Risk Communication and Community Engagement
RHTO	Raes Hadomi Timor Oan
SAGE	Strategic Advisory Group of Experts on Immunisation (WHO)
SEA	Southeast Asia
SHS	Specialist Health Services

Acronym	Description
SIF	Strategic Investment Framework
SOPs	Standard Operating Procedures
TGA	Therapeutic Goods Administration
TTS	Thrombosis with Thrombocytopaenia Syndrome (a rare AEFI)
UNICEF	United Nations Children's Fund
VAHSI	Vaccine Access and Health Security Initiative
VIRAT/VRAF2.0	A vaccination introduction preparedness/readiness assessment tool developed in Indonesia
VPD	Vaccine-preventable disease
VSPD	Vanuatu Society for People with Disability
WHO	World Health Organization

VAHSI Independent Evaluation

1. Introduction

1.1. Context

The COVID-19 pandemic, caused by severe acute respiratory syndrome coronavirus 2, was among the most profound health, social and economic crises that the world has experienced in modern times. As well as leading to the loss of millions of lives, the pandemic caused severe economic and social disruption, shutting down economies, disrupting billions of lives and jeopardising decades of development progress.

Countries in the Southeast Asia (SEA) and Pacific regions were keen to access COVID-19 vaccines as soon as possible to be able to protect their populations and economies. These vaccines were rapidly developed and started to become available from December 2020. Australia quickly established that it could play a crucial role in supporting the region by offering vaccine procurement and supply, policy and planning and ensuring safety and quality – the latter informed by expert technical advice to enable equitable and inclusive access to safe, effective, and affordable vaccines.

The Australian Government established the Vaccine Access and Health Security Initiative (VAHSI) with the goal of supporting equitable and inclusive access to COVID-19 vaccines in the Indo-Pacific region, tailored to need and supported by Australian technical expertise (October 2020 – December 2024).

The eighteen countries in the Pacific and Southeast Asia supported by VAHSI are:

Pacific: Fiji, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu

Southeast Asia: Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Timor-Leste, Vietnam

In 2020 and 2021, the focus of the initiative was procuring and supplying COVID-19 vaccines to countries. In 2022, the initiative continued to supply vaccines to countries, and also offered partner governments delivery support in-country. In 2023 and 2024, VAHSI focused on assisting vaccine delivery. This shift from supplying vaccines to providing delivery support within countries reflected a shift in partner government needs and moving from an initial rapid response phase to a longer-term response phase.

In 2022, VAHSI's scope was expanded to include routine and remedial immunisation for other vaccine-preventable diseases (VPDs). This addressed an emerging need to increase routine immunisation activities that had not taken place in 2020 and 2021, when partner governments were focused on COVID-19 vaccination, and because demand for COVID-19 vaccines had largely been met.

VAHSI funding was augmented by AUD100 million provided as part of Australia's contribution to the Quad Vaccine Partnership and AUD19.2 million bilateral funding for activities in Vietnam and Laos (details in Table 1 below). This Quad-related funding was co-programmed with VAHSI, supporting vaccine procurement and supply across SEA with a particular focus on remote areas and vulnerable populations. For the purposes of this evaluation all funding sources that contributed to VAHSI were included in scope.

Table 1: Detail of investment in scope for this evaluation

Investment	Period	Funding (AUDm)
VAHSI	FY20-21 to FY24-25	523.2
Quad Vaccine Partnership (Southeast Asia only)	FY21-22	100.0
Bilateral funding contributed to VAHSI delivery support agreement and vaccine procurement (Vietnam)	FY20-21 to FY22-23	18.2
Bilateral funding contributed to VAHSI delivery support agreement (Laos)	FY20-21	1.0
Total Funding	FY20-25	642.4

The three components of VAHSI are:

1. **COVID-19 vaccine supply:** Supply of doses to countries from Australia's domestic supply and through regional procurement arrangements with UNICEF. In SEA this was supplemented by support delivered as part of Australia's contribution to the Quad Vaccine Partnership.
2. **In-country delivery support:** Tailored assistance to partner countries' national COVID-19 vaccination programs, including technical advice to national regulators, support for public communication campaigns, cold chain infrastructure, and other logistics capacity. In SEA this was supplemented by AUD24 million as part of Australia's contribution to the Quad Vaccine Partnership.
3. **Regional health security architecture:** VAHSI allocated AUD21 million to establish an ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED) to help SEA prepare for and respond to future pandemics. ASEAN is progressing the required legal framework and financial and administrative arrangements to commence operations. The establishment of ACPHEED is being implemented separately and on a longer-term timeline than other VAHSI activities and is therefore not in scope for this review.

Recognising that structural inequality results in some communities being more vulnerable than others, The Department of Foreign Affairs and Trade (DFAT) worked with delivery support partners to advocate for, and support, equitable and meaningful engagement with diverse stakeholders in planning and safely delivering vaccines within VAHSI countries and engaging diverse communities through inclusive communications. The end of program outcome for VAHSI reflected the prioritisation of the goal of *inclusive* recovery.

1.2. Program overview

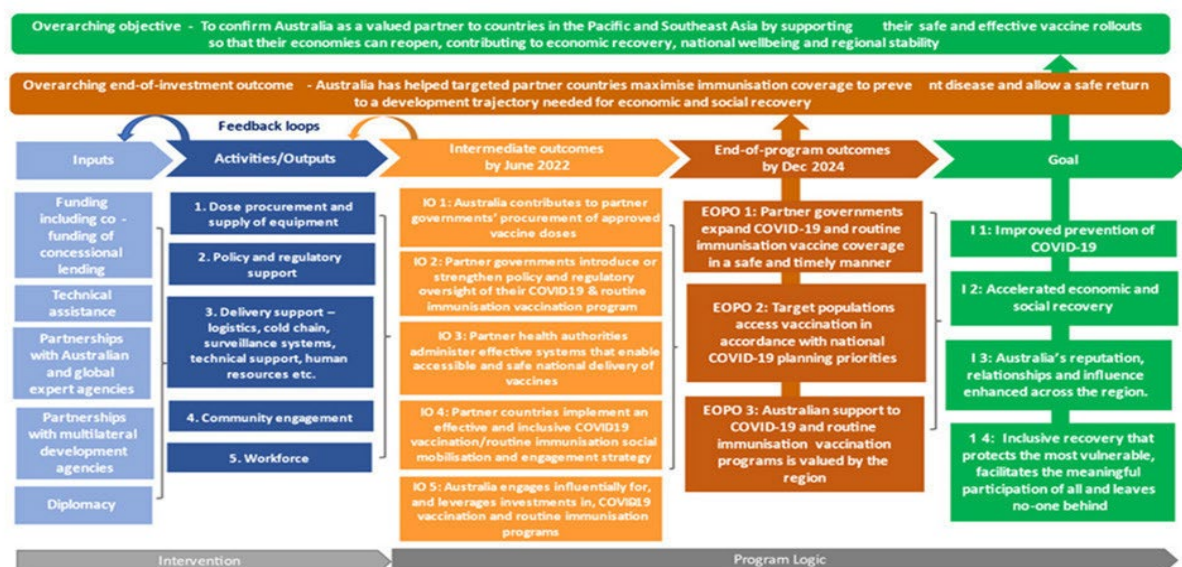
Figure 1 below illustrates how VAHSI investment inputs were intended to deliver outcomes that would contribute to the achievement of a set of strategic goals aligned to the end of investment outcome and overarching objective. The three End of Program Outcomes are:

EOPO1 – Partner governments expand COVID-19 vaccine coverage in a safe and timely manner

EOPO2 – Target populations access vaccination in accordance with each partner country's COVID-19 National Deployment and Vaccination Plan

EOP03 – Australian support to COVID-19 vaccination programs is valued by the region

Figure 1. The VAHSI EOPOs as set out in the Theory of Change (ToC) for the initiative



1.3. Purpose of this evaluation

The evaluation was designed to assess the performance of VAHSI, including co-programmed Quad and bilateral funding, where these contributed to COVID-19 vaccine access and delivery support activities (excluding ACPHEED establishment). The evaluation assessed effectiveness and efficiency, and performance in the areas of gender equality, disability and social inclusion (GEDSI). The evaluation was designed to identify lessons for future programs, in particular health emergency response programs.

DFAT appointed a team under Specialist Health Services (SHS) to conduct this evaluation between July-November 2024.

The primary audience for this evaluation is DFAT staff in Canberra and at Posts in Southeast Asia and the Pacific.

The final evaluation report, or a version thereof, will be published in mid-2025.

2. Methodology

2.1. Approach

The detailed methodology for this evaluation is outlined in the annexed Evaluation Plan (Annex 3).

Desk based. All members of the evaluation team were home-based. Key Informant Interviews (KIIs) were undertaken using Zoom or Teams. There were no face-to-face or in-country interviews.

Case study approach. VAHSI was implemented by a wide range of partners across 18 countries. The evaluation team used a case study approach, selecting four countries that reflected VAHSI's implementation in different development contexts. These were Indonesia, Timor-Leste, Vanuatu and Vietnam. The selection was based on the likelihood of sufficient documentation and interviewees being available to inform the evaluation, to ensure representation across the two geographical regions (Pacific and SEA), and to ensure diversity in terms of size and context. This approach was taken to

ensure that case study evidence could inform more general findings across all VAHSI countries. Further detail on the case study approach is available in the Evaluation Plan (Annex 3).

2.2. Evaluation Questions

The key evaluation questions were:

- **EQ1** - How did VAHSI contribute to safe, effective and accessible COVID-19 vaccine supply; and promote COVID-19 and routine immunization coverage in line with partner country plans in the Indo-Pacific Region? (Effectiveness – EOPO1 and EOPO2)
- **EQ2** - How did Australia's support contribute to stronger relationships between Australia and partner governments? Are there aspects of the support that have been more valued than others, and why? (Effectiveness – EOPO3)
- **EQ3** - How has VAHSI made efficient use of Australia and partners' time, money and resources to achieve outputs and expected outcomes? Was the modality an appropriate mechanism to respond to regional and partner government needs? (Efficiency)
- **EQ4** - To what extent was VAHSI effective in promoting and progressing gender equality and supporting disability equality and social inclusion processes and outcomes?
- **EQ5** - What lessons can be identified that could inform design and implementation of future large-scale regional health emergency response programs, including on GEDSI? (Lessons for future programs).

2.3. Data collection

2.3.1. Document review

The evaluation team completed a review of VAHSI program documents, including those relating to the design, implementation, reporting and Monitoring, Evaluation and Learning (MEL) of VAHSI. This included VAHSI investment design documentation, delivery support proposals and reports, country specific progress reports, and Investment Monitoring Reports (IMRs). The evaluation team also reviewed reports and other documentation from delivery support partners. This provided additional data and enabled additional analysis to contribute to the assessment of the performance of VAHSI. The full list of documents reviewed is included at Annex 1.

2.3.2. Key informant interviews

Over 50 KIIs were conducted. Key informants included DFAT officers based in Canberra during the design and implementation phases of VAHSI, and DFAT officers who were at Post during all stages of its implementation, including the early stages when strategic challenges were at their greatest. KIIs were also conducted with partner government representatives (mainly by questionnaire) and delivery support partners. For the four case study countries – Indonesia, Timor-Leste, Vanuatu and Vietnam – the team interviewed Australian DFAT officers who were at post in these four countries during the response, locally-engaged DFAT officers, delivery support partners and partner government officials (where feasible). The evaluation team also interviewed Australian technical agencies that provided technical assistance to various countries during implementation of the VAHSI initiative. The evaluation team conducted additional interviews with DFAT officers who had been based in a further four non-case study VAHSI-supported countries – Cambodia, Fiji, Papua New Guinea, and Solomon Islands.

From the initial selection of interviewees, based on a suggested list provided by DFAT, additional key informants were identified, often by the initial key informants. This 'snowballing' led to the evaluation

team conducting further interviews beyond the initial scope. A full list of interviewees is included at Annex 2.

KIIs were conducted solely by the evaluation team. For each KII, the interviewing member, or members, of the evaluation team filed a record of the KII in a shared internal team SharePoint folder. The KIIs were not recorded. Only members of the evaluation team attended KIIs. The interview documentation has not been made available to anyone beyond the evaluation team.

2.3.3. Data Analysis

The evaluation team developed rubrics and undertook thematic analysis to guide document review. KII notes were reviewed by all team members to ensure agreement of interpretation.

Initial findings and recommendations were identified by the evaluation team and presented to DFAT Canberra in an interactive session. The reflections and responses from this presentation were captured and included in this report.

Further detail of methodology is outlined in the Evaluation Plan (Annex 3).

3. Limitations and constraints

Based on a purposively selected sample: COVID-19 vaccine supply to partner countries was assessed for all VAHSI countries, as was the effect of VAHSI on Australia's relationships with partner governments. Most other evaluation assessments were carried out on the four case study countries selected for in-depth review. GEDSI was assessed in three of the four sample countries (not Vietnam). Effort was made to ensure geographical representation, different development contexts, and a mix of large and small countries in the selection of case study countries – however, it is recognised that each country, and its experience of the pandemic, was unique. Furthermore, the evaluation team aimed to interview a representative sample of partners and relevant stakeholders. However, due to the sheer volume, not all partners in each of the case study countries were interviewed.

Temporality: There were some challenges related to interviewing stakeholders from partner organisations where current incumbents in the case study countries had not been in their role for long, impacting their ability to fully report on the early phases of the VAHSI program. Conversely, those interviewed who had been involved at the outset had often been out of their VAHSI-related role for more than two years, leading to compromised recall. In only very limited instances was a single interviewee able to report on the full duration of projects / VAHSI initiative.

Desk-based nature of the review: This evaluation was desk-based. This meant there were no in-country visits nor any face-to-face interactions with stakeholders or other members of the evaluation team. In-country visits can be beneficial as there is greater access to stakeholders and the potential for interviewing other stakeholders who might not otherwise have been identified or available. In-country presence can also help with scheduling KIIs and can provide helpful local context. For this evaluation, the team were satisfied that a sufficiently broad range of KIIs took place.

Variability in data reported in partner reports: Overall, there was high variability in the quality and completeness of partner reports. As VAHSI is ongoing at the time of this evaluation, some reports are not yet due to DFAT and have not been assessed by the evaluation team. See Annex 1 for a list of documents included.

4. EQ1 Findings - Effectiveness of VAHSI

This section provides the findings from the evaluation on the effectiveness of VAHSI in contributing to COVID-19 vaccine access and delivery support. The first evaluation question, “How did VAHSI contribute to safe, effective and accessible COVID-19 vaccine supply; and promote COVID-19 and routine immunisation coverage in line with partner country plans in the Indo-Pacific Region?”, explores the extent to which VAHSI investments achieved end-of-program outcomes (EOPOs) 1 and 2. These EOPOs are:

EOPO 1: Partner governments expand COVID-19 and routine immunisation vaccine coverage in a safe and timely manner

EOPO 2: Target populations access vaccination in accordance with national COVID-19 planning priorities

4.1. Evaluative finding

Based on assessment of both COVID-19 vaccine supply as well as vaccine delivery support projects, the evaluation team concludes that VAHSI was effective as an emergency response modality to support countries in the Pacific and SEA, and that EOPOs 1 and 2 will be achieved. Securing COVID-19 vaccines was the highest priority for every country in the world when vaccines became available in 2021, and, recognising this, the Australian Government’s supply of COVID-19 vaccines to countries was expected to be a highly effective form of assistance. This expectation was realised: countries and delivery support partners indicated that Australian Government support through VAHSI was significant and directly benefitted the COVID-19 response. Through VAHSI, Australia supplied 52,078,270 vaccines to countries in the region, in a timely, safe and accessible manner. In most cases, it was not solely COVID-19 vaccines that were supplied; the Australian Government provided equipment to help facilitate vaccine administration, COVID-19 rapid antigen tests, and other supplies – all of which have in turn beneficially impacted the effectiveness of the response. VAHSI also provided significant, effective support to countries through vaccine delivery support projects comprising numerous and diverse activities (described in detail in 4.2.4). Achievements of these projects include the following:

- Improved COVID-19 and routine immunisation coverage
- Reached sub-national levels and/or to hard-to-reach populations
- Delivered in a timely manner given the emergency context and to safe and high-quality standards
- Demonstrated flexibility and adaptability to changing contexts

4.2. Evidence

Findings within this section are structured according to the two main VAHSI priorities of (i) COVID-19 vaccine supply to countries, and (ii) VAHSI vaccine delivery support projects.

4.2.1. COVID-19 vaccine supply to countries

The quantity of COVID-19 vaccines distributed through VAHSI has no precedent with any prior Australian Government international health or development program. From March 2021 to May 2024, the Australian Government supplied 52,078,270 COVID-19 vaccine doses through over 150 deliveries to countries.ⁱ These vaccines were either from Australia's own supply; procured by Australia for partner countries; or the small number distributed through the COVAX Facility (Table 2). Reflecting the development of COVID-19 vaccines internationally and progression of the public response to the pandemic, the initial distributions were of AstraZeneca vaccines, followed by Pfizer vaccines from

December 2021, Moderna vaccines from April 2022, Pfizer paediatric vaccines from July 2022, and BA.1 booster doses from May 2023 (Annex 5).

Table 2: Summary of number of COVID-19 vaccine doses shared to countries through VAHSI

Country	No. deliveries ²	No. doses delivered
Cambodia	4	2,830,530
Indonesia	7	8,395,000
Laos	4	1,504,780
Papua New Guinea	14	335,270
Philippines	7	8,132,080
Thailand	1	452,790
Timor-Leste	13	1,190,040
Vietnam	23	26,461,860
Fiji	28	1,651,100
Kiribati	4	50,500
Nauru	7	24,280
Samoa	8	175,150
Solomon Islands	11	618,200
Tonga	4	76,190
Tuvalu	6	20,500
Vanuatu	7	160,000
Total	148	52,078,270

Notes: Shared from Australia's supply, procured by Australia for partner countries, or distributed through the COVAX Facility. Data to 9 May 2023.² In these numbers it is assumed that multiple shipments of different vaccine types recorded as arriving on the same day were packaged as one shipment.ⁱⁱ

Timeliness of COVID-19 vaccine distribution

Based on vaccine delivery data and consistently positive feedback on Australia's rapid response, the evaluation found that COVID-19 vaccines were distributed in a timely manner, particularly to Pacific Island countries. Feedback through reports and KIIs unanimously demonstrated that Australia responded early, particularly to small island countries vulnerable to COVID-19, which faced challenges accessing vaccines through the COVAX mechanism. Reports and KII feedback identified this as a key achievement and success of the initiative. While the timeliness of early vaccine supplies to countries is most marked to Pacific Island countries, the volume supplied to SEA countries is equally significant, frequently in the millions of doses per country (Figures 2 and 3). Of all the doses supplied to the Pacific Island countries over close to three years, 40.1% were supplied within the first four months of the commencement of vaccine deliveries.

Figure 2: Number of VAHSI COVID-19 vaccine doses supplied by month, Pacific Island Countriesⁱⁱⁱ

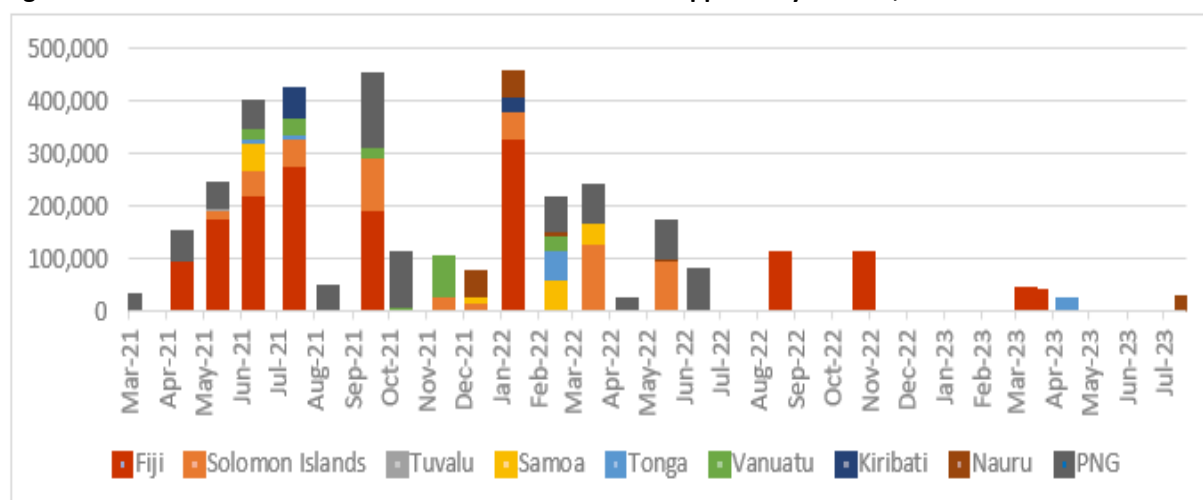
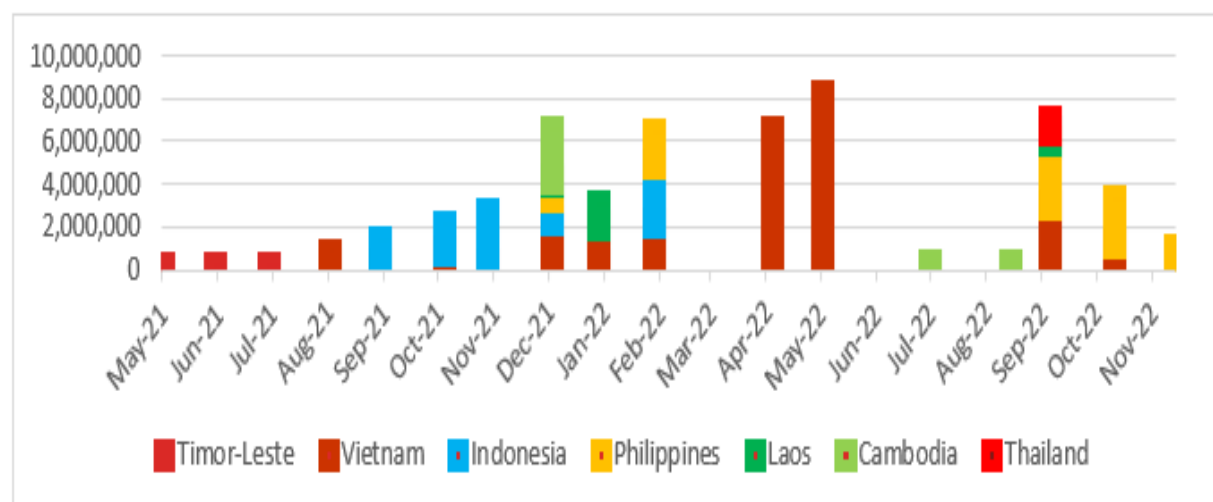


Figure 3: Number of VAHSI COVID-19 vaccine doses supplied by month, Southeast Asian Countries^{iv}



Based on this evaluation, VAHSI COVID-19 vaccine doses are assessed as being effectively supplied to countries in a timely manner to countries throughout the Pacific and SEA.

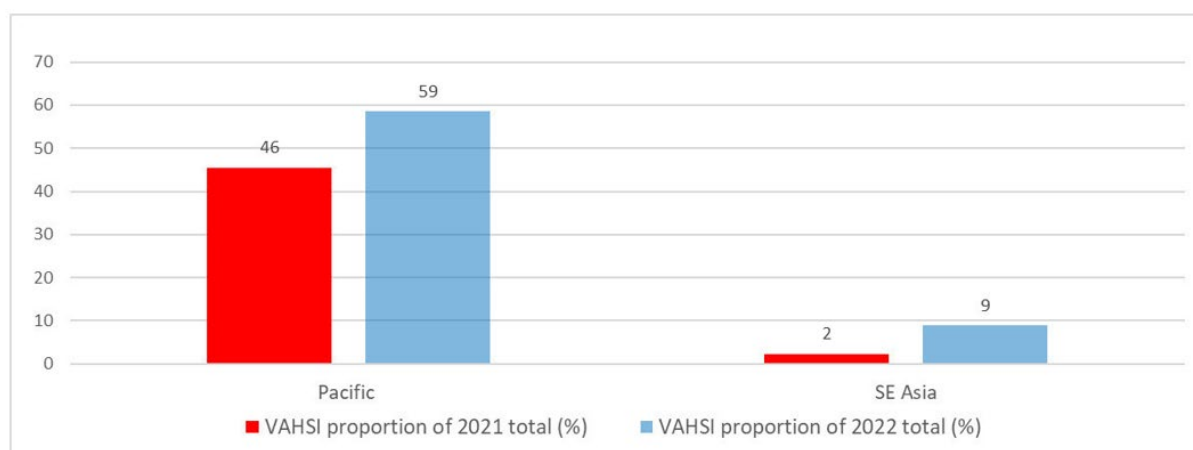
4.2.2. VAHSI attributable proportion of total COVID-19 vaccine doses distributed

Figure 4 shows that the COVID-19 vaccines delivered through VAHSI generally constituted a large proportion of the total number of doses that Pacific Island nations received, in 2021 and increasing as a proportion of the total in 2022¹. While large in volume overall, when measured against hundreds of

¹ An important component of effectiveness is any determination of the proportion of total COVID-19 vaccine doses delivered in countries that could be attributable to VAHSI. However, it is recognised that this generally requires establishing a system to capture this data from the outset, and the pandemic did not lend itself to this. A rough estimate of the VAHSI attributable proportion can be obtained by comparing the number of VAHSI doses delivered to countries with the total number of COVID-19 vaccine doses recorded as administered in those countries. It is important to note in this analysis that the two measures are not identical; rather, this analysis assumes that 100% of VAHSI vaccines delivered were administered to the population within the period. It cannot account for any vaccine wastage that may have occurred in-country (which would influence the denominator), noting that it is not really possible to prescribe a reasonable percentage of vaccine wastage in the context of a pandemic. Furthermore, coverage greater than 100% could indicate that more was provided than the population used or that doses were not distributed (e.g. perhaps demand had reduced, perhaps they are in warehouses, perhaps doses had expired). It does not account for any time lag (e.g. doses delivered in 2022 might not have been administered until 2023) and redistributions between countries are not shown. Data for 2023 are not shown as the VAHSI deliveries stopped. The data shown should therefore be interpreted for general trends and not used as specific, reportable numbers.

millions of doses administered to large populations, VAHSI-supplied vaccines did not comprise a large proportion of the total COVID-19 vaccines that Southeast Asian nations received, except for the smaller nation of Laos (Annex 6). Larger populations often received hundreds of millions of COVID-19 vaccine doses from other sources.

Figure 4: Estimate of VAHSI attributable proportion of total COVID-19 vaccine doses by region² and year, 2021 and 2022^v



The counterfactual is that in the absence of the VAHSI COVID-19 vaccine doses being distributed, Pacific Island countries and smaller countries in SEA would have been considerably worse off, unless they could have secured doses from other sources. This measure, while generalised, provides further evidence of effectiveness of the VAHSI COVID-19 vaccine support to countries that critically needed it.

4.2.3. Effectiveness of COVID-19 and routine immunisation delivery support projects

For the purposes of the evaluation, this was assessed in the four selected countries of Indonesia, Timor-Leste, Vanuatu and Vietnam. This section of the report combines quantitative and qualitative evidence, from all KIIs, and all available delivery support proposals and milestone project reports for these countries. It is important to note that final reports for most of the vaccine delivery support projects were not included as at the time of writing many have not yet been received by DFAT.

Several delivery support partners received multiple grants through VAHSI, often with overlapping time periods and/or in response to required changes of approach within countries as the pandemic progressed. Additionally, other emergency events occurred throughout the pandemic, including the worst floods on record hitting Timor-Leste in April 2021, two Category 4 tropical cyclones striking Vanuatu within 48 hours of each other in March 2023, followed by a Category 5 cyclone in October 2023. Furthermore, several natural disasters affected Indonesia during this time: in 2021 alone there was an earthquake in West Sulawesi, Cyclone Seroja in East Nusa Tenggara, and a volcanic eruption (Mount Semeru) in East Java. These events led to additional humanitarian responses, also often with funding provided by DFAT, frequently involving the same delivery support partners at the same time. Many activities were within the scope of VAHSI, and the nature of delivery support activities chosen for each country was decided following rigorous needs assessment, proposal development, and

² Pacific Island countries were Fiji, Kiribati, Papua New Guinea, Nauru, Samoa, Solomon Islands, Timor-Leste, Tonga, Tuvalu, and Vanuatu. Southeast Asian countries were Cambodia, Indonesia, Laos, Philippines, Thailand, and Vietnam.

review. The program's flexibility meant that activities could also be repurposed to respond to emergencies. In the full picture of effectiveness of VAHSI, the tailored approaches to country needs and this flexibility have consistently been positive attributes. A by-product of this is that some grant activities were frequently rolled into one overarching delivery partner report, or that some delivery support partners, particularly multilateral delivery support partners, frequently provided reporting of the totality of their activities, without specifically differentiating the VAHSI component. Where possible, the VAHSI component has been assessed. It is evident across the entire suite of delivery support partners that, during the COVID-19 pandemic, VAHSI made a significant contribution to COVID-19 and routine immunisation delivery support.

4.2.4. Types of vaccine delivery support

From the beginning of the pandemic, countries were struggling to address their population's needs within their health systems and plan ahead for a time when an effective vaccine might become available. As vaccines started to be developed and marketed internationally, support focused on how these vaccines could be delivered to target populations safely and effectively within countries with health systems of varying capacities. This required rigorous assessments within countries in consultation with Ministries of Health, delivery support partners and with DFAT Posts, and development of tailored vaccine support proposals to address areas of greatest need. A broad range of vaccine delivery support projects were designed and vaccine delivery support proposals submitted to DFAT for approval and funding at multiple points throughout the pandemic. The types of vaccine delivery support included:

Vaccine supply activities: this included supply of syringes, the strengthening of cold chain systems, and providing vaccine waste facilities within countries. Many outcomes from these projects are likely to be sustained beyond the program implementation period. These include strengthened connections between Australia, recipient countries, and delivery support partners to support future vaccine rollouts and broader routine immunization work within VAHSI countries and the region; platforms provided from which to build ongoing immunisation support activities (such as strengthened cold chain, laboratory capacity, health care worker training, communication and social mobilisation which could be used to generate increased demand for routine immunization); and strengthened decision-making at the Ministry of Health level for vaccine rollout strategies. The value-add of these investments is significant, as without this support the countries would not have been empowered to deliver the COVID-19 vaccinations as well as they did within their existing health systems. For cold chain systems, support included the full continuum from vaccine arrival in country, customs clearance and vaccine delivery to national warehouses, monitoring in warehouses, vaccine delivery to subnational areas, monitoring in subnational areas, and vaccine delivery to the health posts, primary health centres and vaccination clinics (or other vaccine delivery/administration points) where vaccines were administered, as well as the provision of equipment to support these activities. Monitoring included total number of vaccines, expiry dates, with considerable emphasis on monitoring vaccine temperature fluctuations while in transit and in storage.

Activities to develop and/or improve vaccination reporting systems: this included monitoring of data nationally, sub-nationally and by at-risk groups, population enumeration and vaccination follow-ups, monitoring of vaccine wastage and leakage, improvements to systems for monitoring and reporting of adverse events following immunisation (AEFI), and monitoring and evaluation of vaccine deployment activities.

Extensive support to vaccine delivery systems sub-nationally: this included establishment of vaccination support centres, door-to-door outreach services, co-administered maternal and child

health services, and other specific pilots and approaches to deliver vaccines provincially and to hard-to-reach municipalities and communities. These required and went hand-in-hand with extensive micro-planning, risk communication and community engagement (RCCE), vaccine demand-generation campaigns at both national and subnational levels, and efforts to reach hard-to-reach groups.

Provision of expert technical advice: this included technical advice related to all aspects of the activities outlined above, extending often to detailed assessments of pharmacovigilance, regulations, and the quality control functions of national regulatory agencies. This also included expert assistance to national task forces (particularly National Immunization Technical Advisory Groups (NITAGs)), for development of guidelines and immunisation strategic plans, vaccine roll-out, tailoring communications, strengthening population monitoring, and development or improvement of vaccine surveillance systems and data management systems. Lastly, there was training supervision and capacity building of staff at all levels of the health system and support for public health laboratories including development of genomic sequencing and quality assurance activities.

Provision of embedded technical support officers³: this included the provision of technical support officers within Ministries of Health and/or multilateral agencies dedicated either to the pandemic response or to the maintenance of other essential health services. Examples include the employment of up to 20 subnational Technical Officers throughout the pandemic period by a multilateral delivery support partner to assist with subnational immunisation support in the worst-affected provinces in Indonesia in direct response to government requests, and a remote delivery support partner deploying an in-country Public Health Physician to provide immunisation support to the Ministry of Health (MOH) in Timor-Leste.

4.2.5. COVID-19 vaccine targets and coverage

Since the start of VAHSI implementation in mid-2021, there is clear evidence from delivery support partner reports that progress was made towards achieving targets. It is not within the scope of this evaluation to assess MEL approaches and reporting. However, there did appear to be variations in expectations related to MEL and reporting (some delivery support partners indicated that reporting requirements were not clear up front or that reporting requirements changed part-way through) and this has made it difficult to determine if targets were achieved for all delivery support partners. Some proposals and reports had set targets, whereas others appeared to only require reporting the 'number of' an activity with no actual target. Most delivery support partners tracked activities to targets, objectives and intermediate or end-of-program outcomes where these had been defined. Most reports provided quantitative data on activities conducted or beneficiaries reached in the reporting period. Most reports included self-assessments of level of achievement towards objectives, with many reports explaining how the data were verified. Progress reports generally provided detail on continued progress, or reasons for delays or deviations from plans. Where delivery support partners reported delays that impacted activities, they frequently included information on overcoming challenges. Some multilateral delivery support partner activities could not be directly attributed to VAHSI.

In late 2022 and early 2023, as COVID-19 transmission, hospitalisation and mortality rates reduced, VAHSI focus shifted from providing COVID-19 vaccines to supporting routine immunisation service delivery. This pivoting reflected a shift in partner government needs as they moved from rapid response to a longer-term response phase. There is considerable direct and indirect evidence that

³ While the technical support was highly valued, a point of feedback was that this was not often matched with provision of administrative and/or coordination assistance to agencies who had a rapidly expanded portfolio of immunisation support activities.

vaccine delivery support projects contributed to higher COVID-19 and routine immunisation coverage. This evidence is drawn from delivery support partner reports (including, but not limited to, AIHSP in Indonesia, AHP in Vanuatu, UNICEF in Timor-Leste and the World Health Organization (WHO) in Vietnam), which include quantitative data on the numbers and types of vaccine doses provided and modality (e.g. to hard-to-reach populations through door-to-door service delivery, mobile clinics, or scheduled vaccination events in communities), regulatory-supported registrations and authorisations of COVID-19 vaccines, and expert advice supporting urgent decisions on use of vaccines.^{vi} For example, indirect evidence included the level of technical advice and support provided to the Ministry of Health for the COVID-19 vaccine rollouts, the design and implementation of immunisation plans, the design and reach of RCCE and other educational campaigns, large multi-agency coordination groups, vaccine distribution activities, provision of cold chain to enable the distribution of vaccines to outreach areas, and training of health care workers. For multilateral delivery support partners such as WHO and the World Bank, where VAHSI-attributable activities were generally harder to discern, there is evidence that an extensive amount of work was undertaken to support governments to respond to the pandemic. An independent assessment of the World Bank work was undertaken which verified that the conditions for the disbursement of loan funds supporting vaccination activities had been completed and accepted.^{vii}

4.2.6. Quality and safety

There is evidence that DFAT was highly cognisant of, and effectively implemented VAHSI to minimise, quality and safety risks, by funding vaccine delivery support activities that augmented the in-country systems already in place. This included funding activities to ensure robust AEFI reporting, enhancing and ensuring processes to monitor vaccine cold chain and expiry dates, regulatory support and safety monitoring, establishing insurance arrangements for VAHSI vaccines, and provision of expert technical advice and transference of evidence-based guidelines from the Australian context to the context of VAHSI countries.

Delivery support partners similarly provided safe and quality support to partner countries throughout the pandemic. Multiple reports noted tracking of and/or obstacles generated by vaccines nearing or past their expiry dates, including remedial actions to maximise access and avoid vaccine wastage prior to expiry. Similarly, several delivery support partners reported training on vaccine storage and cold chain equipment maintenance (including basic refrigerator maintenance at health posts), training to newly recruited Ministry of Health staff, mentoring, training of trainers and knowledge transfer. In addition, delivery support partners conducted supervisory visits to health facilities and communities on all aspects of their projects, expanding as the pandemic situation improved to more face-to-face training to enhance health worker capacity. One government recorded a COVID-19 vaccine wastage rate of less than 2%, noting that this was the lowest rate they had achieved in implementing vaccination campaigns.

In the context of the COVID-19 pandemic, where new vaccines were being introduced internationally, robust safety monitoring systems were important, including ongoing post-market safety monitoring. In the early days of the pandemic there were very few laboratories in the Indo-Pacific region that could regulate vaccines and medicines. Pacific Island countries were particularly vulnerable in procuring vaccines with no assurance that they would work. As part of VAHSI, regulatory support and safety monitoring of Australian Government donated COVID-19 vaccine doses was undertaken by the Therapeutic Goods Administration (TGA), the Australian Government authority responsible for evaluating, assessing and monitoring therapeutic goods. In this world-first arrangement, 74 distinct activities were undertaken that contributed to achieving greater assurance of the quality, safety and efficacy of COVID-19 vaccines introduced into partner countries. This included 46 specific activities

supporting pharmacovigilance.^{viii} TGA responded to requests for evaluation support and supported partner countries to verify the quality of COVID-19 vaccines using internationally recognised Good Manufacturing Practice (GMP) standards.^{ix}

Ministries of Health and delivery support partners highly valued TGA reference laboratory support and reported that, without VAHSI, this support would not have been possible. Through this support, people who had not been involved in the regulatory work became connected, which in turn helped to resolve NITAG clinical and vaccine expiry questions. Importantly, Ministries of Health and delivery support partners indicated that the provision of deep technical linkages through VAHSI, that extended beyond solely donating vaccines, differentiated the Australian response from other donors. This support was also tailored to country contexts and provided early. Delivery support partners reported strong synergy between the evidence-based guidance developed for the Australian Technical Advisory Group on Immunisation (ATAGI), and transference of this information into the contexts of the VAHSI countries. This was particularly important when there were rare but serious AEFIs such as Thrombosis with Thrombocytopaenia Syndrome (TTS), when people were trying to understand complex information, and multidisciplinary teams were brought together often in very strenuous circumstances to try to make carefully considered clinical judgements (see case study). These activities empowered NITAGs in their decision-making and could have bolstered public confidence in vaccines.

The initial priority was supplying COVID-19 vaccine doses to countries, however over time the focus shifted more towards vaccine side effects and AEFIs. As with any vaccine, product information included risks of complications and adverse effects, including possible serious allergic reactions and blood clots. Following international reports of adverse events following vaccination from the AstraZeneca vaccine, delivery support partners noted that people started holding back from receiving it, preferring instead to wait for mRNA vaccines. This further emphasised the importance of pharmacovigilance and robust AEFI reporting. Several delivery support partners supported the implementation of stronger AEFI recording, training and committees. WHO Indonesia reported VAHSI enabled them to provide significant technical assistance for training and establishment of AEFI surveillance. Relative to other countries, there was not a significant impact from AEFIs in Timor-Leste. Vietnam noted extensive training and focus on AEFI-related technical support provided through WHO, improving capacity for the AEFI advisory committee at sub-national level, as well as some purchasing of new refrigerators and procurement of supplies for AEFIs. It is reasonable to conclude VAHSI delivery support met country expectations for AEFI management in the pandemic context.

Case study: Complementary, multidisciplinary expertise for responding to COVID-19 AEFI in Timor-Leste

In addition to VAHSI, Timor-Leste received large donations of COVID-19 vaccines (AstraZeneca, Sinovac, Pfizer) through COVAX and other bilateral donations. Vaccinations commenced in April 2021, around the time that reports of adverse events following AstraZeneca vaccine started to emerge internationally. Challenges associated with communicating the importance and relative safety of COVID-19 vaccines, and monitoring for AEFIs, were substantial. With complementary, multidisciplinary expertise, involving the Ministry of Health, in-country delivery support partners, a deployed in-country public health physician, and additional remote complementary expertise provided by the TGA and NCIRS, support was provided to the NITAG and effective communication specifically targeting health professionals and the community, was delivered. Augmenting this, virtual training was delivered on vaccine safety, recognising and reporting AEFI, where Timorese clinicians could interact with Australian experts in haematology and TTS. This training included a general overview of vaccine pharmacovigilance, epidemiology of TTS and AstraZeneca vaccine, clinical

diagnosis, investigation and management, and discussion of a draft protocol for managing suspected TTS patients in Timor-Leste.

The benefit of these activities was evidenced by rapid uptake of vaccination among health professionals and in the community throughout 2021. One severe AEFI was reported in Timor-Leste during the pandemic. Investigating this, the NITAG technical review committee deemed that it was likely not vaccine related.

Reach to vulnerable groups

For most delivery support projects, there is substantial evidence of reach sub-nationally, and that delivery support partners strove to enhance access to COVID-19 and/or routine immunisation services to vulnerable groups. For further detail on reach to vulnerable groups, see Section 7 – Gender, Disability and Social Inclusion (GEDSI).

4.2.7. Timeliness, challenges and flexibility

Delivery support partner reports provided substantial evidence of striving to achieve results in a timely manner, and a willingness to adapt, often at very short notice, in the face of challenges and change. Many activities were delivered according to anticipated timeframes; however, not all timeframes for all targets could be met, due to reasons beyond delivery support partner control such as when changes were experienced by the Ministry of Health which affected all delivery support partners in the country. An extensive list of challenges that caused delays was reported (Annex 7). These included vaccine supply chain and logistics issues nationally or sub-nationally, misinformation and vaccine hesitancy, broader government and socio-political changes, natural disasters and challenging economic conditions. There was general appreciation expressed by delivery support partners that DFAT Posts recognised the operating landscape which was evolving rapidly, and delivery support partners felt supported by DFAT Posts when these issues were raised.

Actions were undertaken by delivery support partners to overcome challenges. These included strong engagement with government to support uninterrupted vaccine supply and to design and deliver appropriate activities, engagement with national and sub-national committees, and dedicated coordination efforts across all delivery support partners to harmonise efforts and avoid duplication. Based on request from a Ministry of Health, delivery support partners pivoted towards an integrated vaccine approach. Some delivery support partners embedded technical experts in-country and sub-nationally; others leveraged networks and coordinated activities and support to places or spaces where children, their families and individuals congregated. Some delivery support partners undertook vaccine hesitancy surveys to better understand concerns and issues, and integrated activities with health promotion in schools.

The majority of reported challenges relate to the course of the pandemic itself, and very few were within the control of delivery support partners. However, some reported that funding, approval timeframes and MEL processes and timeframes were problematic. For example, a delivery support partner raised that it took a long time after submission of the delivery support proposal to set up the grant agreement, which impacted when and how the work could commence. Furthermore, MEL issues seemed to differ across delivery support partners, with reports of too many MEL processes at the start which became unwieldy in the pandemic context, and other reports of few or no MEL frameworks at the start which became problematic when reporting requirements changed, often in very detailed ways, after 18 months of implementation.

4.2.8. Contribution to health systems strengthening

Based on evidence from KIs and delivery support partner reports, VAHSI has led to sustained improvements in relationships at all levels, and improved platforms for future activities within and between countries. Delivery support partners in the Indo-Pacific report there is now more interest in catalytic funding for end-to-end immunisation support activities than previously - benefiting countries, delivery support partners, academic institutions, and DFAT, with over 20 immunisation projects in the region and more planned. There is more recognition of the value of embedded technical advisors in-country, and these advisors are being introduced into new vaccine service delivery projects, which may be funded from other sources such as GAVI, the Vaccine Alliance. There has been more direct bilateral support into vaccine-preventable disease emergencies. For example, using the VAHSI mechanism more recently to rapidly provide Vietnam with measles vaccines in a recent outbreak to try to prevent major loss of life. This is reported as possible now because of VAHSI. Similarly, Vietnam wants to commence more work with TGA under a regulatory strengthening program. Indonesia's current high-level aims of genomic sequencing and laboratory preparedness, which are now helping with mpox, emerged from COVID-19 support, as did the VIRAT/VRAF2.0 vaccine readiness assessment tool and microplanning approach developed under VAHSI. This has been a significant support to the Government of Indonesia which is currently introducing five new vaccinations at once. Lastly, the new Indonesia Australia Bilateral Health design (2025-2029) will be a shift from the previous health investment to include a stronger focus on partnerships between Indonesian and Australian institutions.

4.3. Key lessons learned

Delivery support partners and Ministries of Health reported a range of key lessons underpinning VAHSI's effectiveness including:

- Pre-existing relationships were vital to the achievement of delivery support in an effective and timely manner.
- DFAT's approach to support effectively enabled delivery support partners to tailor proposals to the priority needs of countries.
- Linking vaccine donations with provision of technical advice was a highly effective approach
- Emergency funding for some delivery support partners allowed flexibility to respond to the changing pandemic circumstances and was highly regarded by those delivery support partners.
- Extensive consultation within countries, with DFAT, and among delivery support partners reduced barriers and was considered highly effective in the pandemic context.

4.4. Recommendations

1. DFAT should implement a modality similar to VAHSI in future emergency situations for provision of vaccines (and potentially other emergency supplies), with emphasis on early bilateral support, as well as maintaining multilateral support.
2. DFAT should facilitate rapid funding approval processes for delivery support proposals during an emergency context.
3. During interpandemic periods, DFAT should continue to prioritise investment in immunisation support that will build capacities and strengthen bilateral relationships with country partners, as well as in-country and multi-country agencies.

4. DFAT should continue to advocate with partner governments for health systems strengthening that builds upon the VAHSI investment and positions countries for more resilience and preparedness for future emergencies.
5. Prior to the end of VAHSI, DFAT should facilitate a knowledge sharing event among VAHSI delivery support partners to share the most salient partner learnings from implementation of the VAHSI initiative in the Indo-Pacific region.

5. EQ2 – Effectiveness EOPO3

This section provides the findings from the evaluation on the second Evaluation Question (EQ2): “How did Australia’s support contribute to stronger relationships between Australia and partner governments? Are there aspects of the support that have been more valued than others and why? (Effectiveness – EOPO3)”. The EOPO is:

EOPO3: Australian support to COVID 19 and routine immunization vaccination programs is valued by the region.

This section is structured to align with the two main elements of EQ2 (i) how VAHSI support contributed to stronger relations and (ii) the aspects of the support that have been more valued, and why.

5.1. Evaluative finding

The evaluation found that VAHSI support contributed to stronger relationships between Australia and partner governments. This was particularly evident from qualitative data. The evaluation team identified substantial and strong evidence of partner government acknowledgement of Australian support to COVID-19 response, as well as media mentions of Australian support, both in social and broadcast media. Consideration needs to be given to the sustainability of these improved relations, particularly with potential, and actual, changes of government in partner countries and with the end of pandemic support. With some exceptions, the positive impact was likely stronger in the Pacific than SEA due to difference in population sizes and therefore the relative importance of Australian support (see section 4.2.2). Partner governments particularly valued the vaccines, and delivery support, but also the flexibility of the program to respond to changing needs and the sense of partnership with Australia.

5.2. Evidence

5.2.1. Stronger relationships

In considering evidence for the positive effect of VAHSI on bilateral relationships, the evaluation team was able to draw on media reporting, documentation provided by DFAT and partners, and evidence from KIIs. There may have been some additional internal DFAT reporting and/or communications that was within sensitive channels that the team was not able to consider in the evaluation, including diplomatic channels of communication (‘cables’).

There is clear evidence of stronger relationships between Australia and partner governments, attributable to the effects of Australian support through VAHSI. At the highest level, this includes the upgrade in strategic relationships with countries in Southeast Asia, notably the Philippines and Vietnam. Australia committed to share AstraZeneca doses with Vietnam in July 2021, the first doses (402,800) arriving in late August 2021. This was covered extensively in local and social media and the receipt of vaccine doses was acknowledged with thanks by the Government of Vietnam. Prime Minister Chinh personally thanked the Australian Ambassador for the commitment of support. During

Foreign Minister Payne's visit in November 2021, Vietnam's Foreign Minister noted Australia's commitment. Further support to Vietnam, including supply of paediatric vaccine doses, further strengthened the bilateral relationship. The Comprehensive Strategic Partnership was announced on 7 March 2024.⁴

There is substantial reporting in documentation reviewed of interactions between partner governments and Australian officials indicating gratitude for Australian COVID-19 support, even in meetings with no relevance to COVID-19 and including communications of gratitude at senior governmental level.

All key informants interviewed who expressed an opinion on whether VAHSI contributed to stronger relationships responded positively. This included delivery support partners as well as DFAT officers and locally engaged staff. There are frequent instances of media and social media reporting on Australian support. Politicians within partner governments also used social media and press conferences to give thanks for Australian support. In 2021 in Indonesia, there was coverage in the national press of the arrival of Australian vaccine doses, with the Indonesian Foreign Minister, Retno Marsudi, announcing the arrival of the first batch on live television.

5.2.2. Reasons why Australian support strengthened relationships

Early vaccine support. It was vitally important to Australia's credibility with partner governments that it was able to provide vaccines early in the response, and notably earlier than other donors (see section 4.2.1). Some countries were able to access vaccines from other sources, including bilateral deals, but Australia was consistent with its early deliveries. However, in some countries, the announcement that Australia would supply vaccine doses created expectations that put pressure on Post to deliver – something that was not within Posts' control – and created some tensions in bilateral relations. This was overcome with the arrival of vaccines.

Responsive to country needs and fast to deliver. From the outset of VAHSI Australia consulted directly with partner governments on what they needed in terms of support for their national vaccination programs. This included both vaccine needs and the development of delivery support proposals, including rigorous needs assessment and review. Australia listened to, and provided countries what they needed, in contrast to some other donors to the region who were perceived as dumping short shelf-life doses and 'talking a good game' about donations while procuring vaccines for themselves. Providing countries with the support they needed was not just providing vaccines and related delivery support, but also providing technical assistance, such as linking Ministries of Health to Australian expertise when it was needed. For example, providing advice on the use of AstraZeneca in the under-50 population.

Flexibility of VAHSI. The flexibility of Australia's support under VAHSI was strongly appreciated. For example, Australia had programmed 10.2 million Pfizer doses for supply to Indonesia in 2022 – the timing being the preference of the country. Given vaccination progress, Indonesia decided these doses would no longer be needed. Rather than dumping, or wasting them, Australia was able to reallocate the doses to Vietnam to fulfil a need for paediatric doses.

Acted as a trusted partner. The evaluation found significant evidence from in-country delivery support partners and DFAT officers, as well as partner governments, that countries treated Australia not simply

⁴ <https://www.pm.gov.au/media/joint-statement-elevation-comprehensive-strategic-partnership-between-vietnam-and-australia>

as a donor but as a trusted in-country partner. This was partly attributed to Australia not imposing onerous conditions on support and working with delivery support partners to reduce the burden on ministries.

Stayed the course. Australian support continued beyond the provision of COVID-19 vaccines and delivery support requested during the Pandemic, to include support for routine immunisation. This was reported as beneficial to the relationship between Australia and partner governments. The pivot to delivery support for routine immunisation is an example of Australia demonstrating its commitment to partner countries in the Indo-Pacific region, not simply exiting once the pandemic was considered over but repurposing funds to respond to countries' changing needs and priorities.

Some cautionary words were reported about the sustainability of the impact of VAHSI on relationships. While there was plenty of gratitude during the pandemic and later with the shift to delivery support for routine immunisation, key informants were cautious about whether the improved relations would sustain into the future. In addition, changes in partner government leading to new faces in Governments could dilute the impact at the level of political leadership. There is also a different view for Papua New Guinea where for some within the Ministry of Health the Australian focus on COVID-19 and adult vaccination was seen as a distraction as the COVID-19 pandemic was not perceived as a pressing issue for the country or vaccinations of adults culturally appropriate. Overall VAHSI was appreciated, but not by all.

5.2.3. Vaccines and delivery support

While it is perhaps obvious that the vaccines were the aspect of VAHSI most appreciated by partner governments, it was not only the supply of vaccines themselves that was valued. Partner governments appreciated that the vaccines were safe and that they were not short shelf-life doses (except in the infrequent circumstances where these were requested – e.g. Vietnam, which was sufficiently effective in its vaccination program to be able to deploy them). They also appreciated that the vaccines came as a package with delivery support interventions through delivery support partners, including multilateral organisations such as WHO and UNICEF, and coupled with technical expertise when needed. In Vanuatu, when there were doubts about the AstraZeneca vaccine, the Australian Government was able to facilitate the provision of expert technical advice from the TGA to partner government counterparts on their use.

5.2.4. Flexibility of VAHSI

As mentioned earlier in this section (5.2.2) the flexibility of Australian support was highly valued and frequently cited in key informant interviews as a notable, appreciated, and positive aspect of VAHSI. This flexibility was most clearly seen in big shifts, such as the shift to support to routine immunisation catch-up support, but also in responsiveness to changing needs of countries over the course of the pandemic. For example, Australian support through VAHSI to the Philippines catch-up immunisation campaign in early 2023, which enabled vaccination of over 50,000 children with measles-rubella vaccines and over 30,000 with bivalent oral poliovirus vaccines.

5.2.5. Technical assistance and Australian expertise

Partner governments highly appreciated that Australia was not just a source of vaccine doses but also provided regulatory assistance through Australian expert institutions to enable the use of new vaccines in countries in the region. The secondment of technical experts to support Ministries of Health was of significant value to countries in the region, not least as it enabled institutional strengthening which could have a long-lasting positive impact. The support to countries to upgrade to e-medical records from previous use of paper records enabled better targeting of populations that

had not been vaccinated. Tonga experienced the effects of a tsunami in 2022 and needed humanitarian support, but there was a reluctance to let humanitarian aid workers into the country before the national vaccination campaign for COVID-19 had taken place. Australia expedited the necessary technical and logistical support to enable Tonga to safely receive and distribute Pfizer doses, thus enabling the arrival of humanitarian support.

5.2.6. Relationship building

Throughout the pandemic, Australia was able to mobilise health and technical specialist agencies (e.g. TGA, Menzies, NCIRS) to assist countries in the Pacific and SEA, including facilitating direct contact between Australian and partner government ministries, doctors and technical specialists. These direct contacts were highly valued by partner governments (e.g. regulatory assistance) and have led to relationships that should continue to strengthen health systems in the region and help to protect Australia's neighbours. The new relationships established through VAHSI continue to lend significant weight to the standing of the Health Security Partnership agencies in the region, evidenced by continuing requests for assistance following the drop off in requests for COVID-19 response. TGA engagement with the Philippines' Epidemiology Bureau under the Australian Expert Technical Assistance Program (AETAP) was well received, as demonstrated by positive written feedback received by TGA from the Philippine's Department of Health.

5.3. Key lessons learned

Delivery support partners, partner governments and DFAT officers reported the following key lessons learned from implementation of VAHSI:

- The importance of being responsive to country needs and prompt in providing delivery support to trust and strengthen relationships with partner governments.
- The importance of flexibility to be able to respond to changing partner country needs and enable the effective and efficient use of resources.

5.4. Recommendations

6. DFAT should ensure that future health emergency response mechanisms are designed to enable flexible deployment of support, resources and programmatic changes in response to changing partner country needs and priorities.

6. EQ3 – Efficiency

This section provides the findings from the evaluation of the third Evaluation Question (EQ3): "How has VAHSI made efficient use of Australia and partners' time, money and resources to achieve outputs and expected outcomes? Was the modality an appropriate mechanism to respond to regional and partner government needs? (Efficiency)

This section is structured to align with the two main elements of EQ3 (i) the efficient use of Australia and partners' time, money and resources, and (ii) whether the modality was an appropriate response mechanism.

6.1. Evaluative finding

It is important to consider the context of the pandemic when assessing the efficiency of Australia and partners' time, money and resources under VAHSI. This was an unprecedented situation and the need to respond at speed to support the region did not allow for the usual investment of time in the design of a multi-country, multi-pronged health program – the ability to supply vaccines quickly was of

primary importance. It is also valid to consider the counter-factual: what would have happened if Australia had not delivered the VAHSI initiative and what alternative mechanisms could have been used to attempt to achieve the same, or similar, outcomes.

The evaluation concludes that overall VAHSI made efficient use of Australia and partners' time, money and resources. This conclusion is drawn from evidence of the appropriate and efficient use of resources to achieve VAHSI's EOPOs (see Section 4 and Section 5). Investments were aligned and coordinated with other donors, delivery support partners, and partner government systems to ensure efficiency and prevent duplication. The mechanism was appropriate as it maximised efficiency through the use of existing partners, programs and networks and built on Australia's long-term investment in health in the region. Australian support came as a package – vaccines, delivery support, technical assistance – tailored to country needs. The combination of bilateral vaccine doses and investment in the multilateral system was considered an efficient overall approach. VAHSI also outperformed alternatives, notably COVAX, in terms of rapid response and flexibility. The mechanism can be considered efficient and appropriate.

There were some inefficiencies, notably bureaucratic, but also reported deviations from budgets and evidence of gaps in skills that reduced efficiency early in the response. Overall, these inefficiencies did not significantly impact implementation, and the issue of skills was largely resolved with the recruitment of additional local expertise (e.g. for delivery support projects).

VAHSI was efficient at raising vaccination coverage levels, and although not within the scope of this evaluation, it was reported to the evaluation team that VAHSI undoubtedly saved lives. This indicates an efficient use of time and resources and demonstrates contribution to Australia's own health security through bolstering the health security of neighbouring countries.

6.2. Evidence

6.2.1. Reporting on efficiency

The VAHSI Performance Assessment Framework (PAF) did not include specific measures on efficiency. Defined indicators on efficiency were not reported against as part of VAHSI reporting and reporting specific to efficiency was not available except as high-level assessments and through some partner reporting (see section 4.2.3, 4.2.5 on partner reporting). The evaluation team has mainly had to draw from qualitative reporting to assess the efficiency of the program, as well as examination of budgets and expenditure. In a future response if efficiency is to be evaluated, it should be built in and clearly defined in the initiative design and MEL. However, there is sufficient evidence available in both documentation and from KIIs, to assess VAHSI was an efficient use of Australia and partners' time, money and resources and an appropriate mechanism to respond to regional and partner government needs.

6.2.2. Use of existing partners and programs

The use of existing partners and programs was efficient as it enabled rapid and smooth implementation by leveraging existing relationships, networks and partnerships to pivot to support for national COVID-19 responses. Key informants stated that Australia's long-term bilateral health investments in several countries were critical to Australia's response. This facilitated quick deployment to support partner governments as relationships and mechanisms were already in place and these could be leveraged with minimal incremental burden. In contrast, for Posts where there was not a bilateral health relationship (notably in SEA) this required some quick uplift to build the

required in-country health relationships. Evidence indicates that, in general, building these relationships has been valuable, contributing to better bilateral relations overall, and whilst valuable for their own sake potentially beneficial in any future emergency health response.

Australian funding for delivery support partners, including WHO and UNICEF, was generally considered efficient and to have achieved significant impact with relatively small amounts. The delivery support projects were a vital complement to the vaccines, enabling access to hard-to-reach areas and vulnerable populations (see section 4.2.4 for detail). The delivery support funding can be considered efficient as existing programs were used to pivot to COVID-19 support and provide rapid responses. Qualitative evidence from KIIs with DFAT officers and delivery support partners suggests that the delivery support projects were considered a good use of taxpayer money; particularly where the investments may have a lasting effect (e.g. on cold chain investments, adoption of Tamanu record system in the Pacific). The evaluation also found evidence of delivery support partners reporting on efficiency (e.g. UNICEF conducting supervision trips at provincial and district levels to ensure efficient as well as effective implementation of VAHSI activities). Wastage was minimised through not over-supplying and through investments in cold chains (see section 4.2.6).

Utilising existing Health Security Partnerships was also efficient (e.g. TGA for regulatory support, NCIRS for technical support for immunisation services, and others). TGA and NCIRS both had capacity building programs in the region and were able to leverage existing program models and relationships. These expert groups coordinated well together and with partners on the ground to prevent duplication.

6.2.3. Fast and flexible

Australia was quicker than most donors to provide vaccine doses in most partner countries in the region. The use of vaccine doses from the Australian domestic supply enabled early support to countries. This political decision, firmly aligned with EOPO3 (see section 5), was efficient in both, a) its low cost – transportation only, and b) responding quickly to the needs of countries. Early response also demonstrated that Australia could be a trusted partner during the response.

The flexibility of VAHSI was important in its effectiveness (i.e. meeting country needs) but also efficient in terms of eliminating potential wastage and responding to changing priorities through the life of the program. The key over-arching example of this is the ‘pivot’ to support routine immunisation catch-up. This occurred across the region as both demand for COVID-19 vaccines dropped off and awareness increased on the need to catch up the cohorts that had missed routine immunisations during the pandemic. Reprogramming VAHSI funds to support routine immunisation was an efficient use of resources and beneficial in terms of sustainability.

A good example of efficiency was in Indonesia when partners (AIHSP, UNICEF, World Bank, WHO) coordinated closely to support response planning, helping to reduce the burden on over stretched Ministries of Health. DFAT’s targeted grant funding towards the achievement of three World Bank disbursement-linked indicators, helping to ensure the achievement of these targets, meant that significant funding was accessed by the country - AUD15m helping to leverage more than USD1bn of concessional World Bank finance. This comparatively small investment had the additional bonus of reinforcing the position of Australia as a trusted partner to the Indonesian Government, notably the Ministry of Health.

6.2.4. Alternative mechanisms

To assess whether VAHSI was an appropriate mechanism, it is instructive to look at alternative mechanisms. Aside from doing nothing, the most obvious alternative mechanism was COVAX, the multilateral program to supply vaccines to 150+ participant countries. Australia invested in COVAX, contributing AUD215m to the global pot and had a prominent role in the governance of COVAX. This is not an evaluation of COVAX, but during the course of this evaluation COVAX has been reported as slow to deliver and unpredictable in both its timelines for vaccine supply and for the actual vaccine itself – not giving countries a choice. Australia stepped in to supply doses in Timor-Leste to fill the gap left by delay in COVAX doses arriving. COVAX also operated with a global equity model that had initial and later phase coverage targets for vulnerable people and healthcare workers. This approach would not have facilitated high early coverage levels in Pacific Island countries with small populations that required a relatively small number of vaccines – something that Australia was able to supply bilaterally through VAHSI. COVAX also struggled to deliver small batch sizes, a problem Australia did not have in supplying Pacific Island countries.

6.2.5. Bureaucratic inefficiencies

With a program as large as VAHSI, covering 18 countries in the Indo-Pacific region, there are inevitably going to be bureaucratic inefficiencies. There is some reporting and evidence of bureaucratic inefficiencies, even some tensions, between Post and Canberra (e.g. a lack of understanding of local context) but nothing to suggest anything out of the ordinary for an investment of this size delivered in an emergency situation. However, the evaluation identified the following inefficiencies:

- **Approval process for the delivery support projects.** The process for approving support proposals was a lengthy and iterative process that involved multiple levels of decision-makers and oversight. This was a positive as it meant there was a high level of senior ownership and oversight of the proposed work, as well as accountability. In practice, in some cases, it also meant that the process for approval was slower than ideal in an emergency response. Later in the implementation, the approvals process was revised to ensure greater rapidity.
- **Vaccine readiness tool.** The vaccine readiness tool was an essential step in assessing countries' needs and their ability to safely accept Australian vaccines. While considered essential, some reporting in KIs to the evaluation team suggested that it slowed down the deployment of vaccines and was perhaps disproportionate to the risk, albeit with the clear and good purpose of appropriate handling of Australian vaccines and minimising wastage.

6.2.6. Staffing

DFAT Canberra was able to implement VAHSI centrally without a major increase in staffing. In contrast, a clear message from Posts during the evaluation was that they did not have enough staff and that when additional DFAT staff were deployed it took too long for them to arrive (e.g. clearance processes for deployment) and in some cases they did not have the specific skills necessary to be able to fully support the response at Post. Locally engaged staff (LES) with knowledge of local context, political economy and the required networks were considered of most value at Post. Not being given the discretion, and funding, to hire additional local staff at Post was reported to be sub-optimal in the management of resources for VAHSI, and that with the ramp up in funding there should have been a commensurate ramp up in staffing at Posts.

6.2.7. Reporting inefficiencies

Reporting was inconsistent during the response. Given the multitude of different delivery support partners across a large number of countries, it was also difficult for DFAT to monitor projects and complete initiative level reporting. In addition, the evaluation team found it difficult to determine in some partner reports what achievements could be attributed to VAHSI support (see section 4.2.3). A streamlined, less complex system that continues to meet DFAT reporting and accountability requirements should be considered for future response (see Section 4.4 Recommendations).

The PAF did not include efficiency indicators which means reporting specific to efficiency was only available through annual investment monitoring reporting and delivery support partner reporting.

6.3. Key lessons learned

DFAT officers, delivery support partners, technical advisors and Ministries of Health reported the following key lessons relevant to efficiency:

- The importance of leveraging existing partnerships to enable rapid and efficient response.
- The importance of investment in bilateral health relationships in partner countries to enable rapid scale-up of support.
- Specific efficiency reporting and indicators are required to enable evaluation of program efficiency.

6.4. Recommendations

7. If not already in place, or under development, DFAT should consider establishing an emergency staffing plan to be able to respond quickly to staffing needs in a regional health emergency response.

7. EQ4 - Gender, Disability and Social Inclusion

This section provides the findings from

the evaluation of the fourth Evaluation Question (EQ4): “To what extent was VAHSI effective in promoting and progressing gender equality and supporting disability equality and social inclusion processes and outcomes?”

Data and analysis for this section is based on KIIs and review of documents from Indonesia, Timor-Leste and Vanuatu. This section is structured to align with the Key Focus Areas of the VAHSI Gender, Disability and Social Inclusion (GEDSI) Strategy which provides the framework for promoting and progressing GEDSI under the VAHSI investment (see Annex 8). To some extent, efforts by delivery support partners in each of these five focus areas serves as a proxy for the extent to which VAHSI GEDSI outcomes and indicators (as defined in the PAF) were achieved, in the context of incomplete reporting and results data.

7.1. Evaluative finding

Overall, evidence indicates that delivery support partners delivered GEDSI-sensitive programming. Almost all delivery support partners responded to partner government prioritisation of high-risk groups and hard-to-reach populations and applied knowledge of gender barriers to access to interventions. The picture for disability was mixed, with some delivery support partners providing high priority focus on including and reaching people with disabilities and others not having the internal policies and processes to ensure that this occurred.

7.2. Evidence

7.2.1. GEDSI advocacy, policy dialogue and negotiation with delivery support partners

Starting from a strong DFAT policy base, the VAHSI Strategic Investment Framework (SIF) reflected prioritisation of the goal of *inclusive* recovery. A VAHSI GEDSI strategy was developed and there is evidence of efforts to socialise this with key DFAT decision-makers and DFAT Posts.

DFAT has sound and easily accessible policies, strategies and guidance notes detailing expectations around GEDSI. DFAT's organisational GEDSI policies, including the Gender Equality and Women's Empowerment Strategy (2016)^x, the Development for All Strategy (2015)^{xi} and Partnerships for Recovery (2020)^{xii} provided a strong institutional grounding for integrating GEDSI into the VAHSI investment. In addition, the Health Security Initiative (HSI) for the Indo-Pacific region provisional strategic framework 2019-22 highlighted gender equality as a cross-cutting theme for selecting, implementing, and evaluating investments under HSI. HSI Guidance Notes for supporting disability inclusion^{xiii} and gender equality^{xiv} provided further practical guidance and insights. All these documents are publicly available and easily accessible online. These are also consistent with the WHO Strategic Advisory Group of Experts on Immunisation (SAGE) prioritisation Roadmap and Values Framework which states 'The overarching goal is for COVID-19 vaccines to contribute significantly to the equitable protection and promotion of human well-being among all people of the world.'^{xv}

The VAHSI SIF expands on the SAGE Framework and notes the need for country level vaccine delivery support programming to considers vulnerabilities and needs of at-risk groups and to ensure priority of access for these populations. The SIF noted that these should be documented in COVID-19 National Deployment Plans (NDVPs) which were developed and owned by partner countries – against which it was hoped that outcomes would be monitored. While monitoring of NDVP outcomes did not form part of this evaluation – DFAT's own Vaccine Response Plans all contained the statement (or a slight variant) that: "The core principle of equity will underpin all our efforts. We remain committed to advancing the Australian Government's strategic policy priorities on gender equality, disability and social inclusion across our vaccine support. We will look for opportunities to both mainstream and target our funding to ensure that no-one is left behind".

This clear and strategic intent of VAHSI to support equitable and inclusive access to COVID-19 vaccines was demonstrated in the upfront allocation of resources to GEDSI in the Centre for Health Security (CHS) with a core team with strong GEDSI and MEL skills appointed to its VAHSI Program Support Unit (PSU). The PSU Team commissioned relevant desktop reviews on GEDSI to inform what was a well-considered and relevant GEDSI strategy for VAHSI. The GEDSI Strategy also contained a clear Action Plan and allocation of roles and responsibilities across the CHS and in-country DFAT teams. Responsibilities variously included advice to delivery support partners on MEL plans and indicators to advocacy and partner dialogue on GEDSI (by DFAT Post). Minutes of Steering Committee meetings demonstrated efforts to socialise the strategy but amidst very packed agendas, very early in the program. Email correspondence demonstrated that the GEDSI Strategy was also shared with DFAT Posts. While there were champions for GEDSI at Post, this was often incidental (i.e. an individual's commitment to GEDSI) and was often later in the life cycle of the VAHSI program. Despite these efforts, it was unfortunate to note during this evaluation that not one country-level stakeholder interviewed could recall seeing or hearing about the VAHSI GEDSI strategy and awareness within CHS (and/or GHD) was similarly limited.

Reasons for this are myriad. Not least, the GEDSI Strategy was released at the height of VAHSI activity and vaccine distribution amidst what one senior DFAT officer referred to as a time of ‘life and death’ decisions. While acknowledging the importance of equity in principle, some key decision-makers interviewed indicated that the priority was mobilising vaccines and establishing associated cold chains, i.e. not GEDSI-related work. There was also an imperative to get vaccines to those most at risk of COVID-19 infection (for example frontline health workers – many of whom are women) rather than traditionally recognised groups at risk of marginalisation. Thus, while the importance of GEDSI was acknowledged, it was not championed in a programmatic sense by senior-level decision-makers.

This evaluation demonstrated that the strongest champions of GEDSI were delivery support partners themselves. As a result, there were multiple strong GEDSI-focused projects under VAHSI. However, the overall message from delivery support partners was that this was supported, but not driven by DFAT.

Delivery support partner ‘champions’ for GEDSI had some advocacy successes with partner governments – notably in Indonesia with the Last Mile initiative, where reaching hard-to-reach populations was advocated and ultimately well supported by both the Ministry of Health and provincial authorities. In some instances, delivery support partners could even demonstrate influencing GEDSI-aware legislative change at the provincial level as a result of their activities.

7.2.2. Consultation and communications

There was significant evidence that delivery support partners developed and/or facilitated effective risk communication and community engagement (RCCE) through developing information, education and communication (IEC) materials that considered the particular needs and concerns of diverse groups in accessible and appropriate ways.

As laid-out in the SIF, targeted communication efforts were one of VAHSI’s key mechanisms for advancing accessibility, equity and inclusion. Data available for the evaluation demonstrated that this occurred most efficiently and effectively where delivery support partners had sound pre-existing strategies for both gender and disability and partners had already undertaken gender and or disability analyses to identify barriers to access – even where this was not vaccine-specific. These delivery support partners also frequently demonstrated established networks and relationships on the ground with both communities and a range of representative organisations, for example, women’s groups and Organisations of Persons with Disability (OPDs). This group of delivery support partners included local NGOs with a history of programming funds from the DFAT Australian NGO Cooperation Program (ANCP) or Australian bilateral health partners (i.e. were well-practised in DFAT expectations regarding cross-cutting issues). A subset of these partners operating under the Australian Humanitarian Partnership (AHP) also demonstrated capacity to undertake rapid ‘emergency’ assessments that were COVID-19 and GEDSI-specific⁵ and rapidly mobilise communication pieces. This report highlighted the highly gendered decision-making around issues such as health (and vaccination) and provided strategies for partners to address this in planning and programming.

Larger multilateral partners also undertook gender analyses to better inform RCCE and IEC materials, but in some instances, these were finalised well after the communication materials had been

⁵ <https://www.care.org.au/wp-content/uploads/2020/04/Vanuatu-Rapid-Gender-Analysis-COVID-FINAL-17.04.20.pdf>

developed. In Indonesia, UNICEF conceded that while efforts were made to address gendered barriers to vaccine access, the needs of people with disabilities were not well considered in the early years of the VAHSI program. UNICEF nevertheless made a valuable contribution with its 2023 report 'Landscape Analysis on Children with Disabilities in Indonesia' designed to identify barriers and bottlenecks to access. Recommendations from that report included improved data capture and coordination plus the development of disability-inclusive and accessible emergency preparedness programs.^{xvi}

In practical terms, these local and perhaps more agile 'DFAT policy-informed' delivery support partners were more able to work effectively with community structures, women's support and/or advocacy groups and OPDs to better identify and quantify hard-to-reach or vulnerable groups and work together with them to tailor communication materials to meet a diverse range of needs. In all three case study countries examined for GEDSI, partners provided multiple examples of consulting with community networks and or OPDs in the process of developing IEC materials. This was either undertaken directly, or through subcontracting arrangements with more relevant or better-connected organisations. In some cases, delivery support partners guided disability groups to develop their own unique communication pieces, for example, an advocacy group for deaf people was supported to develop a WhatsApp video for its membership – reaching 100% of intended targets. In Timor-Leste, a VAHSI partner worked with people who were visually impaired to ensure materials were provided in Braille. Some delivery support partners provided evidence of undertaking (commissioning) research with diverse groups to better understand 'how' different groups want to receive information and 'who' they will listen to. In several instances this resulted in increased outreach using more personalised door-to-door strategies.

The depth of analysis and consultation with communities and or key groups reportedly allowed for an understanding of the depth of vaccine hesitancy, informing the need for multipronged communication strategies utilising a range of modalities (combining mass media with social media and face-to-face strategies) delivered by a range of stakeholders (experts, church leaders, local authorities and local community leaders) where the intention was to not merely inform and educate but to (re) build trust. One key informant reported that in many countries (especially the Pacific) due to low case numbers and low numbers of reported deaths, there was a low fear of the disease, but a very high fear of the vaccine. This further highlighted the need for well-focused communication strategies, particularly in the context of massive misinformation.

It was advantageous that the NGOs associated with both the AHP and the ANCP programs routinely included examples of their communication pieces in six monthly reports. This included providing either hyperlinks (for example to YouTube videos) or embedded files (for example for posters) allowing these processes and GEDSI focused communication pieces to be easily evidenced. DFAT's principal bilateral health partner in Indonesia was invited to present a series of sessions and posters describing its GEDSI-focused approach to RCCE and behaviour change at the 2024 Global Health Security Conference in Sydney. This provided further sound evidence of the focus on targeting marginalised and hard to reach groups.

7.2.3. Community engagement

There was significant evidence that VAHSI delivery support partners actively engaged with diverse community members and representative organisations including women's groups and OPDs to help

inform and provide feedback on COVID-19 vaccination programs and influence vaccine hesitancy, acceptance, confidence and access to vaccine information and services.

The first and biggest barrier to ensuring the inclusion of diverse community members in community engagement activities is to be able to access reliable data. While population data on age and sex was generally available to delivery support partners in most locations through national ministry databases or local authorities, obtaining data on people with disability was in some instances, more complex. For example, in Indonesia, while each Ministry has some data on people with disability, data sets and definitions vary widely, and some Ministries were reluctant to share data at all. Ultimately, in Indonesia, Timor-Leste and Vanuatu, it was connecting with OPDs that allowed delivery support partners to access data about and/or gain access to individuals in respective communities with disabilities. In Vanuatu, the Vanuatu Society for People with Disabilities (VSPD) maintains a database of people with disability, allowing partners to understand the locations of people with disability and the broad range of disabilities that need to be considered in complex emergencies. Partners in Timor-Leste demonstrated close consultation and cooperation with RHTO (*Raes Hadomi Timor Oan*), the principal OPD in Timor-Leste. This cooperation was facilitated in Timor-Leste where VAHSI funded Non-Government Organisation (NGO) partners had a pre-existing partnership agreement with RHTO. However, multiple delivery support partners reported that while partnerships existed with implementing organisations, OPDs were rarely included in more formal ministry or donor-level planning and progress meetings. There may be scope going forward to explore how to better capture and manage data on disability and its management at a national level, ensuring better inclusion and cooperation with OPDs, ministry and donors.

Almost all delivery support partners consulted and/or engaged with OPDs in both the planning and implementation of activities. These engagements allowed delivery support partners to either undertake targeted focus group discussions with people with disability or engage with schools for people with disability. More often at a community level, engagement occurred at a house-to-house level where individuals were either unable or were reluctant to engage in public meetings. Physical access was an issue, not only to vaccine administration sites but in terms of location with a large number of delivery support partners describing not only mobile services but expanded outreach to serve not only older persons and people with disability but those in the hardest-to-reach locations.

Either directly, or through subcontracted local partners, most delivery support partners were able to demonstrate not only the inclusion but also the targeting of diverse groups through community consultation processes. Evidenced both in KIIs and six-monthly reports, delivery support facilitated community dialogue (for example using Mother's Support Groups in Timor-Leste or Women's networks in Vanuatu) to engage and empower women, often with a view to influencing men around vaccination. In some provinces in Indonesia, delivery support partners focused on fathers' groups and male church leaders to become advocates for immunisation while simultaneously supporting women-specific groups as key influencers for immunisation.

By using GEDSI-focused programming, and involving government counterparts, delivery support partners in Indonesia were able to demonstrate significantly higher vaccination rates amongst older persons, prisoners and people with disability in their program districts compared to other similar districts. DFAT's bilateral health program in Indonesia attributed some of its success to what it termed the 'pentahelix approach' which included consulting and engaging broadly involving multisectoral stakeholders; community, government, academia, media, and private sector partnerships.

7.2.4. Monitoring and reporting on GEDSI

VAHSI reporting on GEDSI relied heavily on assumptions of availability of disaggregated data and quality reporting on GEDSI as informed by the PAF. The lack of disaggregated data from a number of delivery support partners and the high variability in the quality of reporting (and subsequent analysis by DFAT) compromised DFAT's ability to adequately monitor delivery support partner GEDSI efforts and achievements.

The overall strategic intent of the VAHSI program was to support 'equitable and inclusive access to and delivery of safe, effective vaccines'.^{xvii} This is formally articulated in the VAHSI Program Logic under Intermediate Outcome (IO) 3: Partner health Authorities administer effective systems that enable *accessible* and safe national delivery of vaccines, and Intermediate Outcome (IO) 4: Partner countries implement effective and *inclusive* COVID-19 vaccination/routine immunisation social mobilisation and engagement strategy. While alluding to GEDSI – there was no stand-alone outcome for gender, disability or social inclusion.

Six (out of a total of 21) indicators in the associated VAHSI PAF were anticipated to be the mechanisms for ensuring that data was collected to evidence effectiveness in terms of equity, inclusion and accessibility. Indicators proposed were substantively based on disaggregated quantitative data to be provided to DFAT in partner six monthly reports. This was based on the assumption that delivery support partners would develop MEL frameworks (MELFs), integrating GEDSI across process and outcome indicators, ensuring a 'line of sight' back to the higher-level initiative reporting system. The PAF also assumed reasonable quality and consistency of reporting from delivery support partners and a process whereby partner reports and data (perhaps at a country level) could be collated for analysis and periodic progress review.

In practice, delivery support partner MEL frameworks frequently bore no resemblance to the expected data requirements in the PAF and reports were of highly variable detail and quality. One DFAT respondent stated that a lot of partner reports were 'not very good at all.' With the notable exceptions of DFAT bilateral health partners and NGOs with experience of reporting under either DFAT's ANCP or AHP programs, almost no disaggregated data was available in partner reports (for example, sex, age, disability or other sociodemographic variables).

Overall awareness of the VAHSI PAF data requirements was very low among delivery support partners and a number of delivery support partners reported struggling with the development of their project-level MELFs in terms of understanding DFAT's minimum data and reporting expectations. While arguments could be made for better socialising the PAF, some respondents who were familiar with the PAF, reported it to be overly complex and difficult to adapt to a project-level MELF. Support and feedback on reporting and MEL system development was reportedly provided to delivery support partners by DFAT in the initial phase of the program including the provision of a standard reporting template. However, not all delivery support partners were receptive to feedback and suggestions and DFAT's MEL supports were not sustained throughout the life of the program.

The drop off in MEL supports was evidenced most starkly in the failure to maintain regular and comprehensive review of all partner reports and provide feedback to delivery support partners in terms of information requirements. Equally importantly, this impacted any effort to attempt some form of collation into annual progress reports which occurred (at a country level) in the first year of the program only. This not only compromised DFAT's ability to monitor progress against indicators

and outcomes but also diminished the value and utility of the PAF as a tool for assessing the overall effectiveness and achievement of intended outcomes.

For a program of this nature – supporting the ‘equitable and inclusive access to and delivery of safe, effective vaccines’ – it is perhaps not surprising that the PAF leans heavily on quantitative data. However, the GEDSI Strategy and indeed the PAF itself does still provide scope for the capture of qualitative data, for example, Indicator 14: Evidence of GEDSI through policy dialogue and programming or Indicator 12: Evidence that partner countries have implemented effective RCCE and social mobilisation strategies to reach key populations. Strategies for capturing this type of qualitative information (‘proactive monitoring pieces’ as referenced in the GEDSI strategy) appears to be missing.

In conclusion, while the evaluation team could focus on the complexity of the PAF, the reliance on quantitative data or the recalcitrant nature of some partners in terms of responding to feedback, an overarching MEL Plan and an associated MEL Guide for partners was missing. That is the step beyond the PAF in terms of communicating expectations communicated to partners including, indicator definitions, how different types of data would be collected and by whom, and how progress and or achievement of outcomes would be measured. This was a significant oversight.

7.2.5. Workforce development

The GEDSI strategy included workforce development with a view to ensuring that training included content on the barriers that groups at increased risk of exclusion and disadvantage face in accessing vaccination information and services and that capacity-building activities be gender equitable and disability-inclusive. Ultimately it was assessed that this was likely overly ambitious and difficult to document. It was not possible to assess this component of the GEDSI Strategy.

7.3. Key lessons learned

Delivery support partners, partner governments and DFAT officers reported the following key lessons learned:

- The inclusion of a Gender Outcome (or intermediate outcome) would have prioritised GEDSI from the inception of VAHSI programming and allowed for continued and commensurate resourcing for the life of the program.
- GEDSI outcomes are achieved by working with local actors with demonstrated understanding of DFAT standards – this was demonstrated through the work of DFAT Accredited NGOs and DFAT bilateral health programs (and their NGO partners).
- Investments need a well-articulated, timely and well-socialised MEL Plan and partner guidelines.
- PAF’s need to be based on realistic expectations of data availability and periodically revised to adjust for any invalid assumptions.
- OPDs were invaluable in many contexts by providing access to people with disability and or relevant data that enabled that connection.
- More broadly, to better understand the impacts on men, women and youth (and older persons), people with disability and other marginalised groups, there is a need for continued advocacy on the collection and sharing of comprehensive sex-, age- and disability disaggregated data (SADDD) on testing, cases, mortality and vaccines – from all partners.

7.4. Recommendations

8. DFAT should ensure development and use of a MEL Plan for complex investments. In addition to a Performance Assessment Framework (PAF), DFAT investments should include an overarching MEL Plan to better articulate broader management of MEL including how different types of data are collected and how progress towards, and achievement of outcomes, are measured – and by whom. This could (or should) be communicated to delivery support partners in a MEL Guide that describes:
 - A. minimum data and reporting requirements
 - B. includes a process to ensure that these are understood and accepted by all funded delivery support partners. and
 - C. that systems are in place for ensuring quality/compliance with these requirements.

Where an overarching PAF is focused on End of Program Outcomes, the MEL Plan should include a description of 'fit for purpose' tools and processes (for example Dashboards or tailored Annual Reports) to strengthen DFAT progress monitoring at the investment level.

9. In recognition of the significant value-add of OPDs to disability inclusion in these situations, DFAT should ensure ongoing support to OPDs, inclusive of supporting DFAT-funded delivery support partners to foster formal and long-term partnerships with OPDs. There may also be a role for DFAT and its delivery support partners to advocate for the inclusion of OPDs in ministry-level planning and coordination meetings.

8. EQ5 – Lessons to inform design and implementation of large-scale health emergency response programs

This section is a summary of key lessons learned from the evaluation of VAHSI to inform the design and implementation of future large-scale health emergency response programs.

- **Bilateral health relationships:** Strong existing bilateral health relationships support an effective and quick health emergency response. Established relationships and networks enable faster deployment of resources and a level of trust that might not otherwise exist. Australian investment in bilateral health relationships is highly beneficial for health emergency responses.
- **Dual approach:** The dual approach of investment in multilateral or international/global-level initiatives (e.g. COVAX) and dedicated country-specific investments ensures countries of interest to Australia are appropriately supported.
- **Partnerships:** Established partnerships that can be drawn upon from the outset of an emergency and effective consultation and coordination of delivery support partners in-country are important in ensuring a rapid response.
- **Tailored support:** DFAT's approach to support effectively enabled delivery support partners to tailor proposals to the priority needs of countries.
- **Linkages:** Linking vaccine donations with provision of technical advice was highly effective in enabling partner countries to deploy vaccine doses safely and effectively. The role played by Australian expert research and health institutes to ensure sharing of best practice and knowledge including for regulatory issues and health information systems was vital, and

helped develop relationships that could prove of longer-term benefit to countries in the Indo-Pacific region as well as to Australian health security.

- **Flexibility and responsiveness:** The importance of flexibility to be able to respond to changing partner country needs and enable the effective and efficient use of resources. The importance of being responsive to country needs and fast to deliver support to trust and strengthen relationships with partner governments.
- **Approval processes:** Some bureaucratic processes, notably for approvals and clearances were considered lengthy, and could be streamlined.
- **Resourcing:** Most DFAT Posts reported that more local skills, networks and knowledge as well as health specialists, development specialists, logistics specialists would have been beneficial to the response. While the VAHSI program continued well beyond its anticipated duration, staffing levels in Canberra did not, with key staff reallocated to new initiatives. This further compromised support to posts and DFAT's capacity to maintain previous levels of activity management. To enable whole of activity monitoring and management, resourcing for staffing in Canberra should be sustained for the entirety of an investment.
- **Data and information:** Delivery support partners reported difficulties obtaining population data to inform program targets, as well as more sophisticated surveillance reporting. For countries such as Australia that other countries look to for support, it is important to ensure rapid supply of accurate information on how this country is managing a pandemic including vaccination, AEFIs, regulation, etc. Technical expertise from Australia can provide a role in supporting countries to rapidly design new policies and programs and make changes to these with a developed country benchmark. This has flow-over benefits to multilateral agencies working in the sector.
- **OPDs:** Many delivery support partners experienced difficulties obtaining data on people with disability, which impacted both planning and programming for inclusion. The clear and strong role of OPDs and the benefits of in-country partners having strong connections (and or formal agreements) with these organisations can allow for rapid access to data and provide mechanisms for accessing people with disability for consultation and broader inclusion in subsequent programming
- **Championing GEDSI:** For initiatives like VAHSI where one of its objectives is: 'Inclusive recovery that protects the most vulnerable, facilitates the meaningful participation of all and leaves no one behind', GEDSI should be an integrated element of the initiative and not seen as an add-on. GEDSI should be understood and accepted (ideally championed) as a cross-cutting priority by all DFAT staff, including senior decision makers. Ultimately it was not just about "getting vaccines out there" but ensuring that the vaccines reached targeted/vulnerable groups and that distinct population groupings received tailored messaging to combat misinformation and vaccine hesitancy.
- **Monitoring, evaluation and learning:** Investments need a well-articulated, timely and well socialised MEL Plan and System. DFAT investments involving multiple partners and partner types need to invest in ensuring that minimum data and reporting requirements are clearly communicated to, understood, and accepted by all delivery support partners (at the outset) and that systems are in place for ensuring quality/compliance with these requirements. If reporting changes are unavoidable, the fit within the MEL Plan, and the capability of delivery

support partners to absorb the change (e.g. if required to collect new data partway through) must be carefully considered and effectively communicated to all delivery support partners. The development of a MEL Plan and associated MEL Guide for partners should be a minimum requirement for programs of this nature. Standard 5 of the DFAT Design, Monitoring, Evaluation and Learning Standards clearly articulates the need for and requirements of MEL Plan and MEL System.^{xviii} Where an overarching PAF is focused on End of Program Outcomes – the MEL Plan should include a description of ‘fit for purpose’ tools or processes (for example Dashboards or streamlined Annual Reports) to strengthen/enable DFAT progress monitoring at the investment level.

- Partner selection (GEDSI):
 - **NGO Partners** - There were significant benefits for DFAT and VAHSI delivery support partners working with NGOs on the ground that had pre-existing networks and relationships (for example to community leaders or groups as well as women’s networks or DPOs). This proved valuable especially for community consultation and mobilisation. These organisations have an in-depth understanding of the context and culture and could often mobilise rapidly as countries transition from the immediate crisis and local communities stabilise. Where this approach was applied it was presented as a key to ultimate success – both for GEDSI and overall. It was noted that in some countries, local NGOs were only engaged (for example by multilateral agencies) in the final year of VAHSI – when conceivably they could have had greater impact if subcontracted earlier in the program and for a longer period.
 - **Existing DFAT partners** – especially DFAT Accredited Australian NGOs (and their in-country partners - including those operating under the AHP groupings) – and DFAT bilateral health programs have a demonstrated commitment to GEDSI. All these types of partners interviewed had pre-existing GEDSI strategies inclusive of analyses of likely barriers to engagement and access, and demonstrated solid networks with community groupings of women’s groups, OPDs and on the whole understood community structures and entry points. All demonstrated a willingness and a capacity to collect the full range of disaggregated data required/expected under VAHSI and reporting from a GEDSI standpoint was of a high standard across the board. AHP in particular brings unique skills/networks for responding to emergencies such as COVID-19 and demonstrate strong outcomes when working as a collective using diverse strategies and approaches. AHP could well have been brought in earlier in more locations to enhance GEDSI outcomes.

9. Acknowledgements

We would like to express our gratitude to the Ministries of Health, the numerous vaccine service delivery support partners, current and former officers from DFAT Posts, and current and former staff from DFAT Canberra who have participated in the evaluation. We wish to thank DFAT Canberra and Specialist Health Services for programmatic and operational support for the evaluation. Lastly, we particularly wish to thank the personnel in the countries in which VAHSI was delivered, including those who worked remotely, for their extensive, excellent and dedicated work during the entire course of the COVID-19 pandemic: our world would indeed have been poorer without your efforts.

List of Annexes

Annex 1: List of DFAT and partner documents reviewed

Annex 2: List of key informants interviewed

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Annex 7: Data collection tools

Annex 8: Number of COVID-19 doses shared from Australia's supply, procured by Australia, or distributed through the COVAX Facility, May 2023

Annex 9: Estimate of VAHSI attributable proportion of total COVID-19 vaccine doses by country and year, 2021 and 2022

Annex 10: Challenges reported throughout the pandemic

Annex 11: VAHSI GEDSI Strategy – Key Areas of Focus

Annex 12: Accessibility description of figures

Annex 13: References

Annex 1: List of documents reviewed

Document	Description	Document Type
Partnerships for Recovery - Australia's COVID-19 development response	Development program policy document during pandemic	Policy document
ODE evaluation of previous infectious disease outbreak activities	DFAT Office of Development Effectiveness evaluation of infectious disease outbreak activities 2006-2015	Background reading
FINAL Report - COVID Vaccine Access and Health Security in Pacific and Timor-Leste and Southeast Asia - 13 June 2023	<ul style="list-style-type: none"> - Internal DFAT audit of VAHSI implementation - Internal management response to DFAT audit of VAHSI implementation 	DFAT quality assurance document
Country level COVID-19 response plans	Country-specific COVID-19 response plans that explained how Partnerships for Recovery would be implemented in partner countries	Policy document
BES progress update Jan to June 2022	Delivery support project routine reporting	MEL document
AETAP RSSM closure report	Delivery support project end reporting	MEL document
SPC PHD VAHSI project June23-March 24 progress report	Delivery support project routine reporting	MEL document
UNICEF DFAT_Routine Immunization Annual Report 2	Delivery support project routine reporting	MEL document
UNICEF VAHSI Delivery support project AR_March 2023	Delivery support project routine reporting	MEL document
VAHSI Collaborative Meeting Minutes 130324	Delivery support project routine reporting	MEL document
WHO DFAT VAHSI RI Annual Report 29 February 2024	Delivery support project routine reporting	MEL document
WHO DPS vaccine Award Technical Report Final 20240424	Delivery support project routine reporting	MEL document
Complete Vanuatu report	Delivery Support proposals and available reporting for four activities undertaken in Vanuatu	Bilateral project reports
Complete BES reports	Delivery Support proposals and available reporting for four activities undertaken by Beyond Essential Systems in the Pacific region	Bilateral project reports
Complete Indonesia reports	Delivery Support proposals and available reporting for activities undertaken in Indonesia	Bilateral project reports
Complete Cambodia reports	Delivery Support proposals and available reporting for activities undertaken in Cambodia	Bilateral project reports
Fiji	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document

Document	Description	Document Type
Indonesia	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Malaysia	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
PNG	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Regional Pacific	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Solomon Islands	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Thailand	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Tonga	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Tuvalu	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Vanuatu	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Vietnam	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
VAHSI Strategic Investment Framework	VAHSI design	Design document
Attachments 1-5	Guidance Note on VAHSI delivery support	Guidance note
VAHSI PAF Changes rationale July 23	Update to PAF mid-2023	MEL document
VAHSI PAF _revised July2023	Update to PAF mid-2023	MEL document
VAHSI Program Logic Updated	Update to PAF mid-2023	MEL document
[UNOFFICIAL TRANSLATION] Government to Government letter of appreciation	Letter to Australian PM thanking Australia for VAHSI contributions	Outcome evidence
Indonesia	Internal reporting 2021	MEL document
Cambodia	Internal reporting 2021	MEL document
Fiji	Internal reporting 2021	MEL document
Myanmar	Internal reporting 2021	MEL document
Laos	Internal reporting 2021	MEL document
Malaysia	Internal reporting 2021	MEL document
Philippines	Internal reporting 2021	MEL document
Samoa	Internal reporting 2021	MEL document

Document	Description	Document Type
Solomon Islands	Internal reporting 2021	MEL document
Thailand	Internal reporting 2021	MEL document
Timor-Leste	Internal reporting 2021	MEL document
Tonga	Internal reporting 2021	MEL document
Tuvalu	Internal reporting 2021	MEL document
Vietnam	Internal reporting 2021	MEL document
VAHSI IMR 2022	Annual Quality Reporting	DFAT quality assurance document
VAHSI IMR 2023	Annual Quality Reporting	DFAT quality assurance document
VAHSI IMR 2024	Annual Quality Reporting	DFAT quality assurance document
Expert Advisory group and Technical advice per program	Technical advice coordinated by Dr Stephanie Williams	Technical advice document
VAHSI budget reconciliation 16 Jan 2024	Table that provides a summary of total doses delivered and delivery support provided, by country (not for further circulation)	Implementation document
Complete Vietnam reports	Delivery Support proposals and available reporting for activities undertaken in Vietnam	Bilateral project reports
Cambodia Delivery Proposal	Technical advice coordinated by Dr Stephanie Williams and Camilla Burkot on delivery support proposal	Technical advice document
Indonesia Delivery Proposal	Technical advice coordinated by Dr Stephanie Williams and Camilla Burkot on delivery support proposal	Technical advice document
Vietnam Delivery Proposal	Technical advice coordinated by Dr Stephanie Williams and Camilla Burkot on delivery support proposal	Technical advice document
Vanuatu and BES option	Technical advice coordinated by Dr Stephanie Williams and Camilla Burkot on delivery support proposal	Technical advice document
VAHSI evaluation - potential interviewees	List of interviewees from DFAT Canberra, DFAT Posts, Delivery Support partners and Gov counterparts	List of relevant contacts
VAHSI Placemat Doses_Oct 2023	List of Australian vaccine deliveries by country by calendar year and mechanism	MEL document
Dose sharing timeline (domestic supply and UNICEF procured) 29092023	List of what vaccine doses were delivered, where, in chronological order	MEL document
Regional Vaccine Support Snapshot (Pacific and SEA activities) 29092023	Summary of VAHSI support by country (doses and delivery support) with examples complete October 2023	MEL document

Document	Description	Document Type
Investment Design Approval Minute AETAP	Internal minute with background to AETAP to approve the designs	MEL document
Investment Design Summary AETAP	Document summarising AETAP design	MEL document
Partner-led Investment Design AETAP-PPI (NCIRS)	Design for NCIRS component of AETAP/VAHSI	MEL document
Partner-led Investment Design AETAP-RSSM (TGA)	Design for TGA component of AETAP/VAHSI	MEL document
AETAP RSSM closure report	Final report for the TGA component of AETAP/VAHSI	MEL document
ANNEX A(a) - Summary Outputs and Outcomes - CLOSURE - AETAP-RSSM Jan 2021 - EOM June 2023	Annex to TGA AETAP final report - summary outputs and outcomes	MEL document
ANNEX A(b) - DATA SUMMARY (TGA-Supported Donated Vaccine Dose by Country)	Annex to TGA AETAP final report - dose delivery support information	MEL document
ANNEX C(a) - GEDSI Independent Review Report	Annex to TGA AETAP final report - Independent assessment of GEDSI outcomes	MEL document
ANNEX C(b) - Case Study One - Equitable access to COVID19 Therapie	Annex to TGA AETAP final report - case study	MEL document
ANNEX C(c) - Case Study 2 - Engagement and Communication Principles - RSP Workshop	Annex to TGA AETAP final report - case study	MEL document
Annex F - MELF	Annex to TGA AETAP final report - monitoring and evaluation framework	MEL document
Fiji (2)	Annex to TGA AETAP final report - case study	MEL document
Master Annex B Training Summary - Closure Report - AETAP-RSSM	Annex to TGA AETAP final report - summary of training completed	MEL document
Solomon Islands (2)	Annex to TGA AETAP final report - case study	MEL document
Timor-Leste (2)	Annex to TGA AETAP final report - case study	MEL document
Papua New Guinea (2)	Annex to TGA AETAP final report - case study	MEL document
2021 09 01_AETAP PPI project report_ Final Version	NCIRS AETAP regular reporting - milestone 2	MEL document
2022-01-19_Revised_AETAP PPI Project Report_Milestone3_Clean_v3.7	NCIRS AETAP regular reporting - milestone 3	MEL document
2022-03-07_AETAP-PPI Annual Report_Milestone 4_Final_v1.1_revised	NCIRS AETAP regular reporting - milestone 4	MEL document
2022-08-02_AETAP-PPI_Milestone 7_V.1.0	NCIRS AETAP regular reporting - milestone 7	MEL document

Document	Description	Document Type
Vietnam - email with proposal attached	Email detailing agreed procurement activities through UNICEF for Vietnam	Implementation document
Cambodia - email with proposal attached	Email detailing agreed procurement activities through UNICEF for Cambodia	Implementation document
Indonesia - email with proposal attached	Email detailing agreed procurement activities through UNICEF for Indonesia	Implementation document
Laos - email with proposal attached	Email detailing agreed procurement activities through UNICEF for Laos	Implementation document
Myanmar - approved proposal	Document detailing agreed procurement activities through UNICEF for Myanmar	Implementation document
Pacific multi-country - approved proposal	Document detailing agreed procurement activities through UNICEF for Pacific multi-country	Implementation document
PNG - email with proposal attached	Email detailing agreed procurement activities through UNICEF for PNG	Implementation document
Timor-Leste - email with proposal attached	Email detailing agreed procurement activities through UNICEF for Timor-Leste	Implementation document
UNICEF SD - email with proposal attached	Email detailing agreed procurement activities through UNICEF for Supply Division head office coordination support	Implementation document
Cambodia - MR campaign - approval AS CHS 19 July 2024	Email detailing agreed procurement activities through UNICEF for Cambodia measles and rubella campaign	Implementation document
Demurrage approval KC to UNICEF - Tonga, Vietnam, Indonesia, Cambodia - 19 July 2024	Email detailing agreed procurement activities through UNICEF for covering demurrage costs	Implementation document
Kiribati - Essential Medicines - AS CHS approval 11 March 2024	Email detailing agreed procurement activities through UNICEF for Kiribati supply of critical medicines	Implementation document
Indonesia - Polio Response - approval AS CHS 31 January 2024	Email detailing agreed procurement activities through UNICEF for Indonesia - polio response	Implementation document
Vietnam - Pentavalent vaccines - AS CHS approval 9 November 2023	Email detailing agreed procurement activities through UNICEF for Vietnam - pentavalent vaccines	Implementation document
Timor-Leste - HPV campaign - approval AS CHS 13 June 2024	Email detailing agreed procurement activities through UNICEF for Timor-Leste HPV campaign	Implementation document
Tonga - MICS - approval AS CHS 2 June 2024	Email detailing agreed procurement activities through UNICEF for Tonga MICS survey	Implementation document

Document	Description	Document Type
Cambodia, Myanmar (2), Kiribati, Laos, Pacific Regional, Philippines, Samoa, Timor-Leste	Country-level summaries of proposed delivery support activities for Foreign Minister approval	Implementation document
Kiribati, Nauru, PNG, Vanuatu, Pacific Regional (AHP, BES, UNICEF)	Internal reporting 2021	MEL document
Annexes submitted to moderators including old PAF	Additional evidence to support VAHSI evaluation process in 2022	MEL document
Outdated PAF	For reference while assessing initial reports	MEL document
Delivery Support Proposals - s23 agreements for delivery support projects	s23s that were specific to each delivery support proposal	Implementation document
VAHSI GEDSI Strategy 2021	Describes underpinning principles and key areas of focus for VAHSI	Guidance document
Gendered approaches to vaccination campaigns 2021	SHS background paper to inform VAHSI	Literature review
Monitoring Access to vaccination programs 2022	Scoping paper commissioned by CHS – interview DPOs in 3 countries regarding barriers to access	Discussion paper
Gender, Disability and Social Inclusion Analysis Report 2023	GEDSI review of ARIA-Ride and AETAP-PPI	Review paper
Evaluating a decade of Australia's efforts to combat pandemics and emerging infectious diseases in Asia and the Pacific 2006-2015	Office of Development Effectiveness (ODE) Evaluation	Reference document

Annex 2: List of key informants interviewed

Key informant interview	Organisation
Ms Sarah Wadley	DFAT - Cambodia
Ms Rochelle White	DFAT - Fiji
Mr John Leigh	Australia Indonesia Health Security Partnership (AIHSP) - Indonesia
Dr Yulianto Kurniawan	AIHSP - Indonesia
Ministry of Health (by questionnaire)	MOH - Indonesia
Ms Rizky Syafitri	UNICEF - Indonesia
Ms Inga Williams & Mr Rodri Tanoto	WHO - Indonesia
Mr Daniel Woods	DFAT - Indonesia
Ms Katie Snowball	DFAT - Indonesia
Ming Toh	DFAT - Indonesia
Ramot Aritonang	DFAT - Indonesia
Ms Kirsten Bishop	DFAT - Indonesia
Mr Somil Nagpal	World Bank - Indonesia
Gita Nasution	AIHSP- Indonesia
Sowmya Kadandale	UNICEF - Indonesia
Anna Gilchrist	DFAT - PNG
Yaman Kutlu	Australian Doctors International (ADI) - PNG
Fiona Mulhearn	DFAT – Solomon Islands
Kat Knope	DFAT – Solomon islands
Dr Shyam Sharan Pathak	UNICEF – Timor-Leste
Deidre Ballinger	DFAT – Timor-Leste
Carli Shilito	DFAT – Timor-Leste

Key informant interview	Organisation
Aidan Goldsmith	DFAT – Timor-Leste
Dr Nahar Nazmun	WHO – Timor-Leste
Angelo Ximenes	World Vision Timor-Leste – Timor-Leste
Mr Richie Rummery & Mr Chris Hagarty	Vanuatu Australia Health Partnership - Vanuatu
Dr Jenny Stephen	MOH - Vanuatu
Ms Kirsty Dudgeon	DFAT - Vanuatu
Patricia Fred	DFAT - Vanuatu
Jennifer Kausei, Vombo Molly & David Cram	AHP Country Coordination - Vanuatu
Carol Angir	Action Aid Australia - Vanuatu
Flora Vano	Action Aid Vanuatu - Vanuatu
Nancy Miyake & Pallen Abraham Philip	World Vision Vanuatu - Vanuatu
Michael Taiki	Save the Children Vanuatu - Vanuatu
Glenise Levendal (Via email)	Care Vanuatu - Vanuatu
Dr Ian Norton & Barbara Daufanamae	Respond Global - Vanuatu
Ms Catherine Gottlieb	DFAT - Vietnam
Linh Dieu Pham	DFAT - Vietnam
Majdie Horden	DFAT - Vietnam
Bridget Collier	DFAT - Vietnam
Muthu Maharajan	UNICEF - Vietnam
Angela Pratt & team	WHO - Vietnam
Ministry of Health (via questionnaire)	MOH - Vietnam
Mr Jason Brown	AHP Support Unit – multiple countries

Key informant interview	Organisation
Dr Felicity Jameson	Therapeutic Goods Administration (TGA) – multiple countries
Prof Kristine Macartney	National Centre for Immunisation Research and Surveillance (NCIRS) – multiple countries
Jo Thomson (AETAP-PPI GEDSI Review)	Learning for Development (L4D) – multiple countries
Bridie Rushton, former Assistant Secretary, CHS	DFAT - Canberra
Dr Stephanie Williams, former Principal Health Specialist, CHS	DFAT - Canberra
Mr Sean Starmer	DFAT - Canberra
Robin Davies, former First Assistant Secretary, Centre for Health Security (CHS)	DFAT - Canberra
Larissa Burke (GEDSI Adviser)	DFAT - Canberra
Keryn Clark (M&E)	DFAT - Canberra
Melissa Kamp (M&E)	DFAT - Canberra

Annex 3: Evaluation plan

Introduction

This document sets out the evaluation plan for the Vaccine Access and Health Security Initiative (VAHSI). The evaluation will take place from July – October 2024.

The Evaluation Plan is informed by several sources including:

Evaluation Terms of Reference (TOR)

Consultations with DFAT

Desk Review of relevant background documentation

DFAT Monitoring and Evaluation (M&E) Standards.⁶

The Plan has been prepared in line with DFAT's M&E Standards (Standard 9) (see Annex 1) and includes five sections: introduction; program background and context; overview of the review; review methodology; Review Team, as well as annexes.

Background and context

The Vaccine Access and Health Security Initiative (VAHSI) was established to support equitable and inclusive access to COVID-19 vaccines in the Indo-Pacific region, tailored to need and supported by Australian technical expertise (October 2020 – December 2024).

The 18 VAHSI countries are:

Pacific: Fiji, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu

Southeast Asia: Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Timor-Leste, Vietnam

In 2020 and 2021, the focus of the initiative was procuring and delivering COVID-19 vaccines to countries. In 2022, the initiative continued to deliver vaccines, and also assisted partner governments to deliver vaccines within countries. In 2023 and 2024, VAHSI focused on assisting vaccine delivery within countries. This shift from providing supply to supporting delivery within countries reflected a shift in partner government needs and moving from an initial rapid response phase to a longer-term response phase.

In 2022, VAHSI's scope was expanded to include routine and remedial immunisation for other vaccine preventable diseases (VPDs). This addressed an emerging need to increase routine immunisation activities that had not taken place in 2020 and 2021, when partner governments were focused on COVID-19 vaccination.

VAHSI funding was augmented by \$100 million provided through the Quad Vaccine Partnership and \$19.2 million bilateral funding for activities in Vietnam and Laos (details in the table below). Quad funding was co-programmed with VAHSI, supporting vaccine procurement and supply across

⁶ <https://www.dfat.gov.au/about-us/publications/dfat-design-monitoring-evaluation-learning-standards>

Southeast Asia with a particular focus on remote areas and vulnerable populations. For the purposes of this review all funding sources that contributed to VAHSI will be in scope.

Table 1: Detail of investment in scope for this evaluation

Investment	Period	Funding (AU\$ in millions)
VAHSI	FY20-21 to FY24-25	523.2
Quad Vaccine Partnership (Southeast Asia only)	FY21-22	100
Bilateral funding contributed to VAHSI delivery support agreement and vaccine procurement (Vietnam)	FY20-21 to FY22-23	18.2
Bilateral funding contributed to VAHSI delivery support agreement (Laos)	FY20-21	1
Total Funding	FY20-25	642.4

The three components of VAHSI are:

1. **COVID-19 vaccine access:** delivery of doses to countries from Australia's domestic supply and through regional procurement arrangements with UNICEF. In Southeast Asia (SEA) this was supplemented by \$17.5 million Quad funding to support dose sharing and \$58 million for procurement in 2021-22.
2. **In-country delivery support:** Tailored assistance to partner countries' national COVID-19 vaccination programs, including technical advice to national regulators, support for public communication campaigns, cold chain infrastructure, and other logistics capacity. In SEA this was supplemented by \$24 million Quad funding in 2021-22
3. **Regional health security architecture:** VAHSI allocated \$21 million to establish an ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED) to help SEA prepare for and respond to future pandemics. ASEAN is progressing the required legal framework and financial and administrative arrangements to commence operations. The establishment of ACPHEED is being implemented separately and on a longer-term timeline than other VAHSI activities and is therefore not in scope for this review.

Recognising that structural inequality results in some communities being more vulnerable than others, DFAT worked with implementing partners to advocate for and support equitable and meaningful engagement with diverse stakeholders in planning and safely delivering vaccines, and engaging diverse communities through inclusive communications. The end of program outcome for VAHSI reflected the prioritisation of the goal of *inclusive* recovery.

Evaluation overview

Evaluation purpose

As stated in the Terms of Reference (TOR): “The purpose of the review is to independently assess the performance of VAHSI, including co-programmed Quad and bilateral funding, where these contributed to COVID-19 vaccine access and delivery support activities (excluding ACPHEED establishment). The review will assess the extent that these investments achieved their health and strategic outcomes, and their performance in areas of gender equality, disability and social inclusion (GEDSI). The review will include the analysis of evidence to develop lessons learned. The findings will inform the VAHSI Final Investment Monitoring Report (due early 2025) and future DFAT health investments, particularly health emergency responses”.

Evaluation Questions

The evaluation questions as stated in the ToR are:

- EQ1 - How did VAHSI contribute to safe, effective and accessible COVID-19 vaccine supply; and promote COVID-19 and routine immunisation coverage in line with partner country plans in the Indo-Pacific Region? (Effectiveness – EOPO1 and EOPO2)
- EQ2 - How did Australia’s support contribute to stronger relationships between Australia and partner governments? Are there aspects of the support that have been more valued than others, and why? (Effectiveness – EOPO3)
- EQ3 - How has VAHSI made efficient use of Australia and partners’ time, money and resources to achieve outputs and expected outcomes? Was the modality an appropriate mechanism to respond to regional and partner government needs? (Efficiency)
- EQ4 - To what extent was VAHSI effective in promoting and progressing gender equality and supporting disability equality and social inclusion processes and outcomes?
- EQ5 - What lessons can be identified that could inform design and implementation of future large-scale regional health emergency response programs, including on GEDSI? (Lessons for future programs)

Intended users of the evaluation

The intended users of the evaluation are primarily within DFAT (Canberra and at Post) and other government ministries involved in global health security, vaccine financing, and preparation and planning for future pandemics.

The evaluation report will be published on the DFAT website. Quality assurance processes will include:

- Specialist Health Service (SHS) quality assurance of evaluation report.
- DFAT review and feedback on draft evaluation report
- Evaluation team finalisation of evaluation report including accessibility check

Evaluation methodology

Key elements of the methodology include:

- Case study focus with multiple stakeholders to provide depth of inquiry, triangulate research findings and collect qualitative data.
- Qualitative and quantitative approaches to develop a comprehensive understanding of achievements and, where possible, contribution.
- Questions that elicit information on what worked, and how the mechanism could be improved for future pandemics.
- Analytical frameworks to support clarity in inquiry, analysis, findings and recommendations.
- Culturally appropriate approaches to ensure that data collection is respectful of evaluation participants.

Sampling

This is a summative, end of initiative evaluation of a significant investment in the supply of COVID-19 vaccines to 18 countries in Southeast Asia and the Pacific and support to their delivery within these countries. As VAHSI encompasses multiple countries there is a need to balance breadth and depth of inquiry to manage within the scope and time frame of the evaluation. It is not possible to assess every country through this evaluation. Therefore, in consultation with DFAT the Review Team has selected four countries: Indonesia, Vietnam, Vanuatu and Timor Leste. Consideration was given to:

- Selecting a mix of countries from the Pacific and SEA.
- Availability of relevant documentation and key informants for interviews within the evaluation period.
- A mix of different delivery support partners.
- Recipients of QUAD funding.
- For each selected country, stakeholders will include:
 - DFAT officials in Canberra and at Post.
 - Relevant partner government officials, particularly Ministry of Health (MoH) officials.
 - Implementing partners including Multilaterals, DFAT bilateral partners, NGOs and other implementing partners at the discretion of the Evaluation Team. This may follow a “snowball” technique as interviews are conducted (that is, based on stakeholder responses a reach-out to other relevant stakeholders as identified) dependent on stakeholder availability and timing.
- Other relevant stakeholders, as identified.

Approach

The evaluation will focus on assessing effectiveness, efficiency and GEDSI, and identifying lessons learned to guide planning and response activities both in preparation for, and during, future pandemics. In alignment with the OECD⁷ DAC evaluation criteria, the Evaluation Team have developed quantitative and qualitative questions for document review and for key informant interviews (KII) (see Annex 2).

⁷ [1] OECD (2021), Applying Evaluation Criteria Thoughtfully, OECD Publishing, Paris, <https://doi.org/10.1787/543e84ed-en>. Accessed 10 July 2024.

Effectiveness

To assess effectiveness of COVID-19 vaccine procurement and delivery the evaluation will focus on the aspects of vaccine safety, effectiveness, and access to the COVID-19 vaccines that were within VAHSI influence. The evaluation will also assess the effectiveness of VAHSI's support of immunisation support and routine immunisations, focusing on the number and type of support activities delivered and how these activities contributed to meeting country needs and expectations. To assess effectiveness the different priorities of VAHSI will be considered.

Of particular importance will be analysis of any information that allows the Evaluation Team to determine effectiveness attributable to VAHSI in a context where vaccine doses and immunisation support activities were supplied from multiple sources at concurrent times. This may include country specific progress reports and ongoing reporting from delivery support providers. In the event it is challenging to quantitatively attribute effectiveness to VAHSI, the Evaluation Team will qualitatively assess these aspects (through document review and KIIs). Under this focus area of effectiveness, the Evaluation Team will analyse evidence where it is available, such as disaggregated data of subnational distribution and investment activity reach, considering both at-risk groups targeted for vaccinations and marginalised or vulnerable people, in accordance with the VAHSI program logic which prioritises GEDSI and aligns with the Sustainable Development Goal (SDG) priority of "leave no one behind."⁸

The Evaluation Team will assess the extent to which outcomes were achieved, and whether there were any unintended impacts, embedded in the context that this pandemic was a rapidly evolving health emergency.

Qualitative evidence (document review and KIIs) will also predominantly be used to evaluate the extent to which, and how, Australia's support contributed to stronger relationships between Australia and partner governments (EQ2), as well as which aspects were more valued than others.

Efficiency

EQ3 is primarily structured around efficiency – determining whether the initiative or intervention delivered results in an economic, operationally efficient, and timely way. Analyses will be descriptive; formal cost-effectiveness analysis will not be undertaken as a component of this review, given a systematic review concluded that COVID-19 vaccination and booster vaccination were cost-effective or cost-saving regardless of the vaccine type; and that vaccine efficacy, vaccine price, vaccine supply or prioritisation, and vaccination pace were the influential factors of cost-effectiveness among different population groups⁹. The judicious, and timely, use of resources is always a key consideration for governments and stakeholder groups and can often influence future

⁸ ^[1] UNSDG (2024), *Leave No One Behind*. <https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind>. Accessed 19 July 2024.

⁹ Fu Y, et al. 2023. Cost-effectiveness of COVID-19 vaccination: A systematic review. *J Evidence Based Med* 16(2):152-65. <https://doi.org/10.1111/jebm.12525>.

investment decisions even in programs that are otherwise found to be highly effective. In accordance with OECD DAC criteria¹⁰, efficiency investigations will include:

Economic efficiency – deviations in the budget, and the assessment of inputs into results as being in the most cost-efficient way

Operational efficiency – how well the resources are used during implementation, whether resources were redirected, logistic decisions optimal, risks managed, and decisions made to enhance efficiency in changing contexts and in harmony with other donors and partner government systems

Time efficiency – whether the results were achieved in the expected timeframe, or whether they were achieved in a timeframe that was beneficial to the recipient, whether there were efforts to overcome obstacles and mitigate delays, and whether there were reasonable adjustments to these given changing context.

It is important to consider the context for assessing the question of efficiency in this evaluation. In a pandemic where a vaccine was initially not available - affecting millions of human lives and entire economies - there were powerful market forces at play when those vaccines subsequently became available. High vaccine purchasing prices in this context, where there was no alternative that could give the same result, was to be expected. The Evaluation Team will ensure recommendations related to efficiency adequately consider context. Measures of economic efficiency extend beyond vaccine purchasing price to vaccine allocation between target countries, vaccine wastage, leakage, and undistributed stock. The Evaluation Team will seek to obtain evidence in these areas.

Gender, Disability and Social Inclusion (GEDSI)

The KEQ for GEDSI requires the reviewers to assess the extent to which VAHSI was effective in promoting and progressing gender equality and supporting disability inclusion processes and outcomes. This evaluation will therefore strive for a balance between examining internal processes of the broader VAHSI initiative in promoting expectations and supporting good practice project management for GEDSI with an examination of partner practices aimed at greater equity and inclusion. The evaluation will seek to take a strengths-based approach highlighting areas of good practice while also identifying lessons learned for future investments.

The evaluation will therefore include significant document review including internal and external DFAT communication pieces regarding GEDSI, design, monitoring and evaluation (DM&E) documentation and selected partner or project-specific reports or work samples (for example communication or community engagement strategies/ GEDSI analyses or strategies – as available). Document review will be supplemented by KIIs where GEDSI will be one of the focus areas. Relevant key informants include key DFAT VAHSI decision makers, key GHD (former CHS) personnel in Canberra and DFAT posts in selected countries plus respondents from VAHSI partners in each of the sample countries ensuring a spread across multilateral agencies, bilateral projects, NGOs and or other actors. While reaching out to disabled people's organisations or women's groups might well

¹⁰OECD (2021), Applying Evaluation Criteria Thoughtfully, OECD Publishing, Paris, <https://doi.org/10.1787/543e84ed-en>. Accessed 10 July 2024.

allow for additional triangulation regarding the reach of GEDSI initiatives on the ground, attribution would be complex and has been considered as beyond scope for this short review.

In keeping with the scope of the KEQ for this evaluation – the evaluation of GEDSI will be principally informed by the VAHSI GEDSI Strategy¹¹. The VAHSI GEDSI Strategy commits to working with partners to implement contextual GEDSI approaches to enhance vaccine acceptance, confidence and uptake and to improve access to vaccine programs. VAHSI's approach to GEDSI is underpinned by the four pillars of equity, rights, accessibility and participation. The Strategy further identifies five key areas of focus for attention by VAHSI:

- Advocacy, policy dialogue and negotiation with partners,
- Accessibility embedded in delivery and communications,
- Community engagement,
- Monitoring and reporting on vaccine access,
- Workforce Development.

These areas will provide a solid framework for assessing GEDSI, further informed by DFAT's COVID-19 Gender and Social Protection Guidance Note¹², Health Security Initiative Guidance Note on Supporting gender equality through DFAT health security investments¹³, Health Security Initiative Guidance Note on Supporting disability inclusion through DFAT health security investments¹⁴, and DFAT's Environmental and Social Safeguard Policy (2019)¹⁵. Review of partner practice will necessarily reference standard good practice in GEDSI across the continuum for example as represented in World Vision's GESI continuum (p. 12)¹⁶.

Lessons Learned

Whilst recognising that VAHSI was not structured with the specific intent of health systems strengthening, given the rapidly evolving emergency response context of the pandemic, a key element of this review is to provide lessons for all aspects of future large-scale regional health emergency response programs, including prevention, preparedness, and response. Qualitative data and analysis through document review and KIIs will be used to identify lessons learned.

Data collection

A complementary set of data collection methods are proposed, recognising the need to capture a range of different perspectives across the multiple country contexts within the VAHSI initiative and within the available timeframe and scope.

¹¹ <https://indopacifichealthsecurity.dfat.gov.au/sites/default/files/2022-08/VAHSI%20-%20GEDSI%20Strategy.pdf>

¹² <https://www.dfat.gov.au/publications/aid/covid-19-gender-and-social-protection-guidance-note-violence-against-women-and-girls-and-gender-sensitive-social-protection-programming>

¹³ <https://indopacifichealthsecurity.dfat.gov.au/sites/default/files/2022-08/Health%20Security%20Initiative%20Gender%20Guidance%20Note%20V2.0.pdf>

¹⁴ <https://surge4genderequality.com.au/sites/default/files/2023-07/Health%20Security%20Initiative%20Disability%20Guidance%20Note%20V2.0.pdf>

¹⁵ <https://www.dfat.gov.au/sites/default/files/environmental-social-safeguard-policy.pdf>

¹⁶ https://www.worldvisionphilanthropy.org/hubfs/resources/Gender_Equality_and_Social_Inclusion%20WV.pdf

- i. **Qualitative and quantitative data** will serve multiple purposes and provide a basis for credible evidence for the evaluation. The document review will be completed by all Evaluation Team members to identify key data and information required to assess the key focus areas, respond to the evaluation questions and inform findings, recommendations and lessons learned.
- ii. **Key informant interviews (KIIs)** will be carried out with stakeholders who have most visibility and understanding of (i) VAHSI and/or (ii) are beneficiaries of, or implementing partners of, the investments in SEA and the Pacific. KIIs will be carried out remotely. Interviewers will take notes, which will then be used to support analysis and the identification of findings, recommendations and lessons learned. All Evaluation Team members will have a role in conducting interviews, maximising the short time available for the evaluation and team member expertise. A full list of stakeholders will be provided to DFAT. The list is under development at the time of finalisation of this Evaluation Plan (Annex 4). Although the identity of many relevant stakeholders is known, the final list will be informed by both the document review and the interviews. The final list of stakeholders consulted will be appended to the Evaluation Report. Known stakeholders include:
 - DFAT officials both in Canberra and at Post, including managerial, technical level and advisory across the duration of the Initiative.
 - Ministry of Health counterparts in the countries selected for case studies.
 - Partners involved in VAHSI support activities in the countries selected for case studies.

Analysis

Analysis will be guided by the evaluation questions set out in Section 3.2 above and will involve quantitative descriptive statistics and qualitative methods. Qualitative analysis will be carried out through thematic analysis of responses in line with the evaluation questions.

Comparative analysis of data collected will identify commonality or contention within and between different stakeholder groups. Where consensus across multiple stakeholder groups is evident, this will be stated in the evaluation report; as will instances where there are differences or outliers. To support confidentiality, only stakeholder groups (not individuals) will be identified in the evaluation report.

The evaluation report will also reference evidence that substantiates findings and link findings to the investment context and the initiative, with members and geographic location. Triangulation of data, especially in the country case studies, will strengthen the confidence in review findings. The multiple dimensions of comparative analysis will include analysis:

1. across different data collection methods
2. within like stakeholder groups
3. across different stakeholder groups
4. across and within different country, regional contexts relevant to the initiative

Evaluation limitations

Potential limitations to the evaluation and mitigation strategies are presented in Table 2, below.

Table 2: Limitations and mitigation strategies

Limitation	Mitigation strategy
<p>Changes to context throughout investment term: VAHSI priorities changed over the course of the pandemic, with the initiative including, at times, vaccine supply to delivery support (which at times included expansion of support of routine immunisations).</p>	<p>Ensure the EQs are designed to evaluate the two elements of vaccine supply and delivery support within the initiative. The different phases of the initiative will be used in analyses as relevance of some priorities changed during implementation.</p>
<p>Selection of countries: due to time trade-offs for completing the evaluation, it is not possible to focus on all 18 countries. Countries differ in their local contexts and a risk of this approach is that some locally relevant content may be missed.</p>	<p>An approach of part-purposive and part-randomisation for the selection of countries ensures that this is as balanced as possible. Purposive selection of countries where there is a quantity of data evident from initial document review allows for the evaluation to cover breadth of scope. Random selection of countries ensures that every other country has equal odds of being selected. Application of a further “snowball” approach, if time and resources permit, will enable consideration of additional country information, should salient features of another country be identified in stakeholder (particularly implementing partner and DFAT) interviews.</p>
<p>Paucity of data and/or reporting: VAHSI is an emergency measure that was extended to have greater scope with funding being diverted bilaterally. Given the length of the program, there is a risk of missing ongoing partner reporting. Lack of ongoing reporting, and therefore data may inhibit the measurement of achievement of outcomes, particularly in terms of assessing effectiveness, impact and GEDSI if there is limited disaggregated data available. A key question is whether the evaluation will be able to assess not just the size of the impact, but also be able to identify how the initiative made an impact.</p>	<p>If data paucity is encountered, the Review Team will try to determine effectiveness through triangulation and validation of the data that are available, and to determine measures of effectiveness through other sources (e.g. KIIs).</p> <p>Similarly, as vaccine doses were supplied from multiple sources at concurrent times, attribution of causality or the determination specifically of the VAHSI contribution may be challenging and by necessity reduced to assessments of high-level impact (national reduction in SARS-CoV-2 cases or national measures of COVID-19 vaccine coverage) only. It is for this reason (and assessments of access) that the Evaluation Team will analyse subnational and disaggregated data and, where possible, distribution dates of VAHSI doses or doses that remained as ‘stock on hand.’</p>

Limitation	Mitigation strategy
Availability of stakeholders for case studies and interviews	<p>Work with DFAT to identify representative sample early and DFAT send initial introductions to signal the importance of the evaluation.</p> <p>Communicate early with stakeholders to schedule meetings within evaluation timeframe.</p> <p>Identify ‘back-up’ stakeholders in case key stakeholders are not available.</p>
Obtaining sufficient evidence from stakeholders	<p>Identify several relevant individuals within relevant stakeholder groups for interview to ensure personal experiences are revealed and captured to inform findings.</p> <p>Draw on interviews and documents.</p>
Quality of documentation, particularly reporting, may jeopardise quality of evidence and findings	<p>Limitations of the key documents (inaccurate, biased or incomplete) will be acknowledged as a limitation of the review.</p> <p>Triangulation of document data and stakeholder perspectives to verify information in documents.</p>
Timeline to carry out data collection and analysis is relatively short	<p>Prepare schedule of activities and send invitations (to participate in review) as soon as possible.</p> <p>Prepare analysis framework to provide clear and simple structure for analysis and to generate (transparently) key review findings.</p> <p>Data analysis completed in sequential phases.</p> <p>Use of evaluation team debrief sessions to support sense-making of findings.</p>
Balancing the volume of findings with the need for a concise report	<p>Strong analytical frameworks developed to align with the evaluation questions, to provide a clear link between evidence, findings and recommendations and enable synthesis and brevity.</p> <p>Use of annexes in the review report to provide additional details.</p> <p>Findings to be substantiated with illustrative evidence – including dominant and outlying themes.</p>

Schedule

In line with the TOR, the evaluation will be carried out between July - October 2024. Key milestones and deliverables are outlined in the below table. A more detailed review schedule is provided in

Annex 4. Evaluation schedule

Indicative date	Milestone
24 July 2024	Draft Review Plan submitted to DFAT for review
12 August 2024	Final Review Plan accepted by DFAT
14 August 2024	Interviews commence
20 September 2024	Initial High-level Findings Presented to Stakeholders
4 October 2024	Draft Review Report submitted to DFAT for review
8 November 2024	Final Review Report submitted to DFAT

Evaluation team

The evaluation will be conducted by a team of independent consultants contracted by Specialist Health Service (SHS). The team is comprised of Mr Andrew Freeman, Dr Suzy Ossipow and Ms. Deb Hartley.

Andrew will provide overall leadership of the review and project management. He will lead on consultations and be responsible for the delivery of all key deliverables to a high standard. He will be responsible for oversight of team inputs and ensuring delivery of outcomes and milestones. He will also be responsible for ensuring all feedback from DFAT and other stakeholders is addressed and that the final report is fully accessible.

Suzy is the health specialist on the team. She will provide health technical input to the evaluation design, and will provide health technical input and analysis to inform the evaluation findings and recommendations.

Deb is the GEDSI and health lead on the team. Deb will provide technical input on GEDSI for the evaluation design, and provide GEDSI technical input and analysis to inform the evaluation findings and recommendations.

The evaluation team will hold regular remote team meetings, in addition to ongoing email communication, to ensure that all approaches, processes and deliverables draw on the individual experience, expertise and responsibilities of each team member. All team members will be involved in document review key informant interviews, analysis and identification of findings and recommendations, and development of deliverables.

Annex 5: Standard 9: Independent Evaluation Plans

No.	Element	Reference in Review Plan
9.1	The Plan is based on a collaborative approach	Section 1
9.2	The program to be evaluated is described and the purpose and primary intended users of the evaluation are clearly identified	Section 3
9.3	A summary is provided to orient the reader to the overall evaluation design and methodology	Section 4
9.4	Limitations or constraints on the evaluation are described (for example time frame, resources, available data, political sensitivities)	Section 4.5
9.5	The key evaluation questions are supplemented by detailed descriptions and/or sub-questions	Annex 2
9.6	It is clear which questions are considered to be of higher priority and are expected to provide the most important information	Section 3.2 and Annex 2
9.7	There is sufficient flexibility to be able to address important unexpected issues as they emerge	Section 4
9.8	The methods to collect quantitative and qualitative data, including stakeholders to be interviewed are described for each question (or related questions)	Section 4 and Annex 2
9.9	The proposed data collection methods are appropriate for the questions posed	Section 4
9.10	Triangulation of data collection methods is proposed to strengthen the confidence in the findings	Section 4
9.11	The sampling strategy is clear and appropriate for the evaluation questions posed	Section 4.1
9.12	The Plan describes how data will be processed and analysed	Section 4
9.13	The Plan identifies ethical issues and how they will be addressed	n/a
9.14	The process for making judgments is clear, including the strength of evidence for making these judgements	Section 4
9.15	Approaches to enhance the use of findings are outlined (if requested in the terms of reference)	n/a
9.16	The Plan provides an indicative schedule which DFAT uses to create the final schedule	Section 4.6 and Annex 4
9.17	Roles and responsibilities of team members, DFAT and any reference group are clear	Section 5
9.18	The Plan describes how the evaluation will be quality assured	Section 3.3
9.19	The Plan for publication of the final Report is documented	Section 3.3

Annex 6: Detailed Sub-Questions against KEQs and Method

This table sets out a subset of data to be sought in document review and questions for key informant interviews.

Review Question (EQ) 1. How did VAHSI contribute to safe, effective and accessible COVID-19 vaccine supply; and promote COVID-19 and routine immunisation coverage in line with partner country plans in the Indo-Pacific region? (Effectiveness - EOPO1 and EOPO2)

Document review (quantitative and qualitative data analysis)

By country (emphasising case study countries):

Vaccine supply:

- Safety & Effectiveness: Number of safe and approved COVID-19 vaccine doses delivered to country through VAHSI (ideally by vaccine type, month and year of delivery), as a proportion of total doses from all sources (and their delivery timeframes if known, and any delays vs planned delivery times). N COVID-19 vaccine doses reallocated to another country due to absorption issues.
- Safety: Evidence of improved AEFI reporting systems and monitoring for COVID-19 vaccination and routine immunisation.
- Effectiveness & Efficiency: Evidence of appropriate management of vaccine wastage/leakage.
- Effectiveness & Access: Immunisation coverage at key time points (subnational if available) (fully/partially/unvaccinated). Immunisation coverage disaggregated by age group, sex, high-risk group where available. Evidence of VAHSI contribution to this (timescale analysis).
- Access: Evidence of vaccine access within country to high-risk groups/vulnerable populations.

Immunisation delivery support:

- Number and type of promotional event/media supported by VAHSI investments. Evidence of effectiveness (qualitative and quantitative).
- Number and type of other activity funded by VAHSI. Number and/or % of activities delivered (compared to country plan, any deviations from plan and reason for deviation? Evidence that activity was timely, accessible, safe (qualitative and quantitative) and/or led to improvements

Sub questions to be answered by the Review (to inform Key informant interviews (KII; qualitative data). Note, these may be revised based on documentary findings)

Q1: Based on your experience, what do you think has been the most significant change that (i) VAHSI (ii) the investment/project has contributed to?

Q2: How did (i) VAHSI (ii) the investment/project contribute to the changes? Probes if required: What were the key strengths? What was highest value? What were the key challenges? How were these addressed? (Interviewer to consider effectiveness: quantity, timeliness, concordance with stakeholder plans, but also safety, accessibility)

Q3: Considering the pandemic context, did the vaccine doses meet country partner needs? (Y/N, specify)

Q4: Did vaccine delivery timeframes meet country expectation/usefulness (Y/N, specify)

Q5: Did adaptations to vaccine supply meet changing country partner needs over time? (Y/N specify)

Q6: Based on your experience, do you feel that coverage targets for high-risk groups were met? (Y/N, specify)

Q7: Were doses available when needed/requested of central warehouse, in sufficient quantity? If not, what were the challenges experienced?

[Q1 and Q2 above to be tailored to specific projects]

EQ2. How did Australia's support contribute to stronger relationships between Australia and partner governments? Are there aspects of the support that have been more valued than others, and why? (Effectiveness - EOPO3)

Documentary evidence of stronger relationships potentially including diplomatic correspondence, reporting, advocacy and/or investment and training and/or supply chain investments and/or sustainability planning, media, new agreements, political statements. Preferred partner status for vaccines, delivery support. Reciprocal agreements in other areas.

Q1. Based on your experience, has the support from Australia contributed to stronger relationships between 'X partner government' and Australia? In which areas in particular? and why? Can you provide any documentary evidence to support this?

Q2. How did Australia's support to 'X partner government' compare to support received from other sources (e.g. bilateral deals, multilateral/regional deals/support, COVAX, other)?

Q3. What were the most valuable aspects of Australia's support (COVID-19 vaccines, delivery support, RI) and how did this change over time?

EQ3. How has VAHSI made efficient use of Australia and partners' time, money and resources to achieve outputs and expected outcomes? Was the modality an appropriate mechanism to respond to regional and partner government needs? (Efficiency)

Documentary evidence of use of country/partner time and resources, potentially assessing data on how long it has taken countries to access other COVID-19 vaccines or other routine vaccines as a comparator, risk management decisions and results.

Use of Australia's resources – summarised cost per dose, Australian Government (Canberra and Post) views of the value of the spend.

Examples of responsiveness to partner government needs, reallocation of doses.

Q1. Given the situation, and the response required, would you assess VAHSI as making efficient use of time, money, and resources to achieve its outcomes? Were there potentially other mechanisms that could have been more efficient? What could be different in terms of a mechanism for future pandemics?

Q2. Based on your understanding of partner government needs, was the VAHSI mechanism an appropriate means of support/response? If so, why? If not, what could be improved, or done differently for future pandemics?

Q3. Did the investments deliver any unexpected outcomes in response to changes in the operating context? (Y/N, specify)

Q4. To what extent did the investments remain relevant to Australia's policy priorities and national interest, over the life of the investment?

Q5. To what extent did the investments align with the partner government's development priorities and beneficiary needs?

To what extent was VAHSI effective in promoting and progressing gender equality and supporting disability equity and social inclusion processes and outcomes? How has ongoing reporting and analysis informed process changes to protect the most vulnerable and promote meaningful participation of all? (GEDSI)

- Evidence of Gender analysis / strategy to inform programming
- Evidence of disaggregated data (gender, age, disability and or other vulnerability indices)
- Documentary evidence of whether the intended target groups, including people with disabilities and the most disadvantaged and vulnerable were targeted/ benefitted equally from the intervention.
- Examples of good practice (analysis/programming where applicable)

Indicative Sub questions to provide basis for KII Interviews (to be tailored depending on stakeholders):

Q1. Through its management of this initiative, to what extent was DFAT able to communicate and support its strategic policy position regarding GEDSI as detailed in the Strategic Investment Framework (and respective policies)?

Q2. To what extent did the VAHSI M&E system serve to capture progress against GEDSI expectations and thus provide scope for response?

Q3. Was vaccine delivery equitable, and how can we know? What were the biggest challenges to equitable delivery? Was disaggregated data available?

Q4. To what extent were barriers to vaccine access identified and how (for example through GEDSI analyses – either pre-existing or VAHSI specific)?

Q5. Were women, people with disabilities and other marginalised groups (and or their representative organisations) meaningfully engaged in the planning, decision making and implementation of programs?

Q6. Were GEDSI considerations /barriers incorporated into training and other workforce development activities?

Q7. To what extent did partner communication products/public health information address accessibility /GEDSI concerns?

Q8. What evidence is there of effective strategies to address GEDSI in programming (including illustrative stories of good practice)?

Q9. What might you do differently next time to ensure gender equality and enhance the targeting and or inclusion of people with disabilities / vulnerable groups?

What lessons can be identified that could inform design and implementation of future large-scale regional health emergency response programs, including on GEDSI? (Lessons for future programs)

Evidence of whether the intervention caused higher-level effects (such as changes in norms or systems), was transformative, or led to other changes (intentional or otherwise), including “scalable” or “replicable” results. Evidence of the most and least valued aspects of the intervention, strengths, weaknesses, and lessons learned.

Q1. Based on your experience do you think this investment/project has been relevant to the local context and key stakeholders? If yes, how so? If not, why not? Initiated by researcher and/or policy-political directions? PROBE: adapt/ change as a result of the COVID-19 pandemic | changes appropriate?

Q2. Were there any tensions or trade-offs that could be learnt from, and did these have any implications? Have these remained?

Q3. Do you think the changes you have mentioned will endure, will continue now the investment/project has finished?

Q4. Based on your experience, what would be your recommendations for improving a program such as VAHSI if it had to be implemented in future? Are there any areas where you would recommend improvements?

Annex 7: Data collection tools

Interview guides used in the evaluation: Note, interviews were semi-structured and therefore questions were often tailored /not rigorously followed in all circumstances.

- Interview guide for DFAT officials
- Interview guide for vaccine service delivery partner
- Interview guide for Ministry of Health
- Interview guide for GEDSI interviews

Interview guide for DFAT personnel

Before the interview begins, remind the interviewee:

- **Objectives of this interview**
 - ***This is not an evaluation of them or their work, but of the VAHSI initiative***
 - ***All responses will be kept confidential; no names will be used in the report***
 - ***Do they have questions or clarifications?***
-

EQ1: These questions are designed around the first End-of-Program Outcome, which is that “Partner Governments expand COVID-19 and routine immunisation vaccination coverage in a safe and timely manner”

Q1: Based on your experience, what do you think have been the most significant changes that VAHSI contributed to? Prompt for details if required.

Q2: How do you feel that VAHSI contributed to the changes? Probes if required: What were the key strengths? What was highest value? What were the key challenges? How were these addressed?

Q3: Considering the pandemic context, do you feel that COVID-19 vaccine doses and timeframes met country partner needs, and/or changing country partner needs over time? (Y/N, specify)

Q4: Do you feel that COVID-19 vaccination coverage targets for high-risk groups were met? (Y/N, specify)

Q5: Considering the pandemic context, do you feel that the immunisation delivery support projects met country partner needs in terms of quality, access/coverage, and timeliness? (Y/N, specify)

Q6: How do you feel that the immunisation delivery support projects expanded COVID-19 and routine immunisation vaccination coverage? Probes if required: What were the key strengths? What was highest value? What were the key challenges? How were these addressed? (Interviewer to consider effectiveness: quantity, timeliness, concordance with stakeholder plans, safety, accessibility)

EQ2. These questions are designed around the third End-of-Program Outcome, which is that “Australian support to COVID-19 vaccination programs is valued by the region”.

Q7. Based on your experience, has the support from Australia contributed to stronger relationships between ‘X partner government’ and Australia? In which areas in particular and why? Can you provide any documentary evidence to support this?

Q8. How did Australia’s support to ‘X partner government’ compare to support received from other sources (e.g. bilateral deals, multilateral/regional deals/support, COVAX, other)?

Q9. What were the most valuable aspects of Australia’s support (COVID-19 vaccines, delivery support, routine immunisations (RI)) and how did this change over time?

EQ3. These questions are around how VAHSI made efficient use of Australia and partners' time, money and resources to achieve outputs and expected outcomes including whether the modality was an appropriate response mechanism?

Q10. Given the situation, and the response required, would you assess VAHSI as making efficient use of time, money, and resources to achieve its outcomes? Were there potentially other mechanisms that could have been more efficient? What could be different in terms of a mechanism for future pandemics?

Q11. Based on your understanding of partner government needs, was the VAHSI mechanism an appropriate means of support/response? If so, why? If not, what could be improved, or done differently for future pandemics?

Q12. Did the investments deliver any unexpected outcomes in response to changes in the operating context? (Y/N, specify)

Q13. To what extent did the investments remain relevant to Australia’s policy priorities and national interest, over the life of the investment?

Q14. To what extent did the investments align with the partner government’s development priorities and beneficiary needs?

EQ5: The remaining questions relate to learning lessons for future programs

Q15. Based on your experience, what would be your recommendations for improving a program such as VAHSI if it had to be implemented in future?

Q16. Were there any tensions or trade-offs that could be learnt from, and did these have any implications? Have these remained?

Q17. Do you think the changes you have mentioned will continue now the investment has finished?

Q18. Is there anything else you think we should know?

Interview guide for Implementing Partner

To assist the interviewer, it is recommended to have a list of the investments/projects that this Implementing Partner has undertaken, and note down the approx. total value of these.

Before the interview begins, remind the interviewee:

- *Objectives of this interview*
- *This is not an evaluation of them or their work, but of the VAHSI initiative*
- *All responses will be kept confidential; no names will be used in the report*
- *Do they have questions or clarifications?*

EQ1: These questions are designed around the first End-of-Program Outcome, which is that “Partner Governments expand COVID-19 and routine immunisation vaccination coverage in a safe and timely manner”.

Q1: Based on your experience, what do you think have been the most significant changes that VAHSI contributed to? Prompt for details if required.

Q2: How did the investment to [implementing partner] contribute to the changes? Probes if required: What were the key strengths? What was highest value? What were the key challenges? How were these addressed? (Interviewer to consider effectiveness: quantity, timeliness, concordance with stakeholder plans, but also safety, accessibility, and cross-check that all main projects/investments of this Implementing Partner have been discussed)

Q3: Considering the pandemic context, do you feel that the immunisation delivery support projects met country partner needs in terms of quality, access/coverage, and timeliness? (Y/N, specify)

Q4: How do you feel that the investment contributed to expanded COVID-19 and routine immunisation vaccination coverage? Probes if required: What were the key strengths? What was highest value? What were the key challenges? How were these addressed? (Interviewer to consider effectiveness: quantity, timeliness, concordance with stakeholder plans, safety, accessibility)

EQ2. These questions are designed around the third End-of-Program Outcome, which is that “Australian support to COVID-19 vaccination programs is valued by the region”.

Q5. Based on your experience, has the support from Australia contributed to stronger relationships between the partner government and Australia? In which areas in particular and why? Can you provide any documentary evidence to support this?

Q6. Based on your experience, how did Australia's support to the partner government compare to support received from other sources (e.g. bilateral deals, multilateral/regional deals/support, COVAX, other)?

Q7. What were the most valuable aspects of Australia's support (COVID-19 vaccines, delivery support, RI) and how did this change over time?

EQ3. These questions are around how VAHSI made efficient use of Australia and partners' time, money and resources to achieve outputs and expected outcomes including whether the modality was an appropriate response mechanism?

Q8. Given the situation, and the response required, would you assess VAHSI as making efficient use of time, money, and resources to achieve its outcomes? Were there potentially other mechanisms that could have been more efficient? What could be different in terms of a mechanism for future pandemics?

Q9. Based on your understanding of partner government needs, was the VAHSI mechanism an appropriate means of support/response? If so, why? If not, what could be improved, or done differently for future pandemics?

Q10. Did VAHSI deliver any unexpected outcomes in response to changes in the operating context? (Y/N, specify)

Q11. To what extent did VAHSI remain relevant to Australia's policy priorities and national interest, over the life of the investment?

Q12. To what extent did VAHSI align with the partner government's development priorities and beneficiary needs?

-The remaining questions relate to learning lessons for future programs

Q13. Based on your experience, what would be your recommendations for improving a program such as VAHSI if it had to be implemented in future?

Q14. Were there any tensions or trade-offs that could be learnt from, and did these have any implications? Have these remained?

Q15. Do you think the changes you have mentioned will continue now the Program has finished?

Q16. Is there anything else you think we should know?

Interview guide for Ministry of Health

To assist the interviewer, it is recommended that the interviewer note down IN ADVANCE whether the MOH was a stakeholder or a funded service provider. If a stakeholder, use this guide. If a funded service provider, use the Interview Guide for Implementing Partners.

Before the interview begins, remind the interviewee:

- *Objectives of this interview*
- *This is not an evaluation of them or their work, but of the VAHSI initiative*
- *All responses will be kept confidential; no names will be used in the report*
- *Do they have questions or clarifications?*

EQ1: These questions are designed around the first End-of-Program Outcome, which is that “Partner Governments expand COVID-19 and routine immunisation vaccination coverage in a safe and timely manner”.

Q1: Based on your experience, what do you think have been the most significant changes that VAHSI contributed to? Prompt for details if required.

Q2: How do you feel that VAHSI contributed to the changes? Probes if required: What were the key strengths? What was highest value? What were the key challenges? How were these addressed? (Interviewer to consider effectiveness: quantity, timeliness, concordance with stakeholder plans, but also safety, accessibility)

Q3: Considering the pandemic context, do you feel that the vaccine doses met your country’s needs, and changing needs over time? (Y/N, specify)

Q4: Do you feel that COVID-19 vaccination coverage targets for high-risk groups were met? (Y/N, specify)

Q5: Considering the pandemic context, do you feel that COVID-19 vaccine wastage and leakage was within acceptable limits, or did you feel that there were areas of wastage or leakage? (Y/N, specify)

Q6: Considering the pandemic context, do you feel that the immunisation delivery support projects met country partner needs in terms of quality, access/coverage, and timeliness? (Y/N, specify)

Q7: How do you feel that the immunisation delivery support projects expanded COVID-19 and routine immunisation vaccination coverage? Probes if required: What were the key strengths? What was highest value? What were the key challenges? How were these addressed? (Interviewer

to consider effectiveness: quantity, timeliness, concordance with stakeholder plans, safety, accessibility)

- These questions are designed around the third End-of-Program Outcome, which is that “Australian support to COVID-19 vaccination programs is valued”.

Q8. Based on your experience, has the support from Australia contributed to stronger relationships between ‘X partner government’ and Australia? In which areas in particular and why? Can you provide any documentary evidence to support this?

Q9. How did Australia’s support to ‘X partner government’ compare to support received from other sources (e.g. bilateral deals, multilateral/regional deals/support, COVAX, other)?

Q10. What were the most valuable aspects of Australia’s support (COVID-19 vaccines, delivery support, RI) and how did this change over time?

EQ3. These questions are around how VAHSI made efficient use of Australia and partners' time, money and resources to achieve outputs and expected outcomes including whether the modality was an appropriate response mechanism?

Q11. Given the situation, and the response required, would you assess VAHSI as making efficient use of time, money, and resources to achieve its outcomes? Were there potentially other mechanisms that could have been more efficient? What could be different in terms of a mechanism for future pandemics?

Q12. Did VAHSI deliver any unexpected outcomes in response to changes in the operating context? (Y/N, specify)

Q13. To what extent did VAHSI align with the Partner Government’s development priorities and beneficiary needs?

The remaining questions relate to learning lessons for future programs

Q14. Based on your experience, what would be your recommendations for improving a program such as VAHSI if it had to be implemented in future??

Q15. Were there any tensions or trade-offs that could be learnt from, and did these have any implications? Have these remained?

Q16. Do you think the changes you have mentioned will continue now the investment has finished?

Q17. Is there anything else you think we should know?

Interview guide for GEDSI

Before the interview begins, remind the interviewee:

- *Objectives of this interview*
- *This is not an evaluation of them or their work, but of the VAHSI initiative*
- *All responses will be kept confidential; no names will be used in the report*
- *Do they have questions or clarifications?*

Partner Specific: Could you describe your particular project (s)/program and how / what stage engaged with DFAT VAHSI – was that integrated into pre-existing programming / additional?

Q1. DFAT Expectations: Through its management of this initiative, to what extent was DFAT able to communicate and support its strategic policy position regarding GEDSI as detailed in the Strategic Investment Framework (and respective policies)? Were you aware that VAHSI had its own GEDSI Strategy?

Q2. Reporting: To what extent did the VAHSI M&E system serve to capture progress against GEDSI expectations and thus provide scope for response? Did you use VAHSI reporting templates? Did you have scope to provide the expected disaggregated data (gender, disability etc) – report against the Performance Assessment Framework (PAF) – or have visibility of same? Feedback on reporting from CBR/Post – regarding GEDSI/ disag data etc ?

Q3. VAHSI was intended to provide “inclusive and equitable access to vaccines - Was vaccine delivery inclusive and equitable, and how can we know? What were the biggest challenges to equitable delivery (include here the availability of disaggregated data?)

Q4. To what extent were barriers to vaccine access identified and how (for example through GEDSI analyses – either pre-existing or VAHSI specific)? I.e. Were partners broadly undertaking GEDSI analyses for either COVID vaccine / routine vaccination programs- was this guided by the GEDSI Strategy or internal strategy and guidelines?

Q5. Were women, people with disabilities and other marginalised groups (and or their representative organisations) meaningfully engaged in the planning, decision making and implementation of programs? Do you have examples of where women, people with disabilities and other marginalised groups etc involved? i.e. not just as a community collective – but as focused groups?

Q6. Were GEDSI considerations /barriers incorporated into training and other workforce development activities? Do you have any awareness of where GEDSI was mainstreamed into workforce training?

Q7. To what extent did partner communication products/public health information address accessibility /GEDSI concerns? Do you have any examples of particularly effective examples ?

Q8. What evidence is there of effective strategies to address GEDSI in programming (including illustrative stories of good practice)?

Q9. What might you /DFAT do differently next time to

6. ensure gender equality and

7. enhance the targeting and or inclusion of people with disabilities / vulnerable groups

Q10. Anything else you think that we should know – but I haven't asked ?

Annex 8: Number of COVID-19 doses shared from Australia's supply, procured by Australia, or distributed through the COVAX Facility, May 2023

A: Pacific Island countries

Date delivered	Fiji	Solomon Islands	Tuvalu	Samoa	Tonga	Vanuatu	Kiribati	Nauru
May-21	120,000	0	0	0	0	0	0	0
Jun-21	200,000	13,000	7,000	0	0	0	0	0
Jul-21	241,000	50,000	0	50,000	9,000	20000	0	0
Aug-21	300,000	50,000	0	0	10,000	30000	13,000	0
Sep-21	0	0	0	0	0	0	8,000	0
Oct-21	215,000	100,000	0	0	0	20,000	0	0
Nov-21	0	0	1,600	0	0	30000	0	500
Dec-21	0	50,000	0	2,000	0	30000	0	0
Jan-22	0	37,800	0	12,000	0	0	2,200	500
Feb-22	351,000	50,000	100	0	0	0	27,300	5,850
Mar-22	0	0	11,800	70,200	54,990	30,000	0	5,850
Apr-22	0	150,930	0	40,950	0	0	0	
Jun-22	0	116,470	0	0	0	0	0	6,600
Sep-22	88,920	0	0	0	0	0	0	0
Nov-22	91,980	0	0	0	0	0	0	0
Mar-23	24,000	0	0	0	0	0	0	0
Apr-23	19,200	0	0	0	0	0	0	0
May-23	0	0	0	0	2,200	0	0	0
Aug-23	0	0	0	0	0	0	0	4,980

B: Southeast Asian countries^{xix}

Date delivered	PNG	Timor-Leste	Vietnam	Indonesia	Philippines	Laos	Cambodia	Thailand
Mar-21	8,480	0	0	0	0	0	0	0
May-21	10000	70,000	0	0	0	0	0	0
Jun-21	2000	105,000	0	0	0	0	0	0
Jul-21	7990	103,200	0	0	0	0	0	0
Aug-21	0	300,000	402,800	0	0	0	0	0
Sep-21	20,000	0	300,000	1,000,000	0	0	0	0
Oct-21	96,500	0	800,000	1,200,000	0	0	0	0
Nov-21	60,000	100,000	0	2,400,000	700000	0	0	0
Dec-21	0	100000	2,281,100	1,095,000	0	100,000	2,350,530	0
Jan-22	0	259,740	1,793,190	0	0	905,580	0	0
Feb-22	0	0	2,214,810	2,700,000	1,432,080	0	0	0
Mar-22	20,000	0	0	0	0	0	0	0
Apr-22	25,000	0	6,451,200	0	0	0	0	0
May-22	100	152,100	8,017,800	0	0	0	0	0
Jun-22	25,200	0	0	0	0	0	0	0
Jul-22	0	0	0	0	0	0	196,800	0
Aug-22	60,000	0	0	0	0	0	283,200	0
Sep-22	0	0	3,000,960	0	3,000,000	499,200	0	452,790
Oct-22	0	0	1,200,000	0	2,001,600	0	0	0
Nov-22	0	0	0	0	998,400	0	0	0

Annex 9: Estimate of VAHSI attributable proportion of total COVID-19 vaccine doses by country and year, 2021 and 2022^{xx}

Country/Region	Total COVID-19 doses administered 2021 ¹	Estimated VAHSI proportion of 2021 total (%)	Total COVID-19 doses administered 2022 ¹	Estimated VAHSI proportion of 2022 total (%)
Fiji	1,270,000	85	280,282	190
Kiribati	102,001	21	102,778	29
Nauru	15,094	3	14,236	132
Samoa	256,403	20	185,532	66
Solomon Islands	243,402	108	382,554	93
Tonga	132,743	14	67,620	81
Tuvalu	9,890	87	14,246	84
Vanuatu	160,805	81	170,350	18
Cambodia	30,460,000	8	14,770,000	3
Indonesia	273,020,000	2	170,560,000	2
Laos	7,130,000	1	3,980,000	35
PNG	509,072	40	201,414	65
Philippines	108,850,000	1	60,950,000	12
Thailand	0	0	37,440,000	1
Timor-Leste	1,200,000	65	778,513	53
Vietnam	151,820,000	3	113,640,000	20
Pacific	2,190,338 ²	81	1,217,598 ²	106
SEA	572,989,072 ²	2	402,319,927 ²	9

Annex 10: Challenges reported throughout the pandemic

There were various challenges that delivery support partners reported as causing delays. These included:

- Inaccurate vaccine and population (and vulnerable group) data, out of date census information, inadequate health information system capabilities
- Inability to provide direct assistance due to not being able to travel (operating remotely)
- Insufficient vaccine supply at national and/or local level, logistic access challenges, preferences for certain brands of vaccines over others, vaccines nearing or past their expiry dates
- Misinformation, uncooperative religious or community leaders, conflicting local and traditional beliefs, and at times ineffective delivery of health information. This contributed to severe vaccine hesitancy in some countries
- Government elections, political instability, ministerial portfolio changes and departmental restructures, government vaccine guidance or policy, delays in government approval processes or budgets, high rates of country's Ministry of Health staff turnover, health workforce capabilities, and a hacked government internet
- Delays caused by the circulating SARS-2-CoV strain (e.g. when Omicron circulated in Indonesia)
- Over time, reductions in the number of COVID-19 infections which led to government de-prioritisation of COVID-19 vaccines, closure of various vaccination centres, shifting to other health priorities and integrating COVID-19 response activities, delaying or discontinuing some existing planned activities. A shift to routine immunisation support also often increased the need to reach more participants
- Slow uptake of vaccine and booster doses later in the pandemic, accompanied by public complacency
- Natural disasters, other infectious disease outbreaks
- Challenging and often worsening economic conditions, volatile prices, threatened livelihoods, and the voluntary administration of a national airline

Annex 11: VAHSI GEDSI Strategy – Key Areas of Focus

1. Advocacy, policy dialogue and negotiation with partners

Through dialogue and negotiations with partners, we will advocate for agreements, designs, implementation and monitoring of COVID-19 vaccination programming to integrate GEDSI and to reflect the policy requirements of DFAT and partners. Where it is feasible for us to do so, we will additionally seek to influence country-level planning and data collection activities to consider and include groups at increased disadvantage – and gather evidence on how Australia has supported the incorporation of GEDSI considerations into partner Government COVID-19 vaccination programs.

2. Accessibility embedded in delivery and communications

The investment will advocate for communication products and vaccination programs – including consent processes and feedback mechanisms – to consider and address the particular needs and concerns of diverse groups in accessible and appropriate ways.

3. Community engagement

Where community engagement activities are planned, we will encourage this to actively engage with diverse community members and representative organisations (including, for example, women's groups and organisations of people with disabilities) to help inform and provide feedback on COVID-19 vaccination programs and influence vaccine hesitancy, acceptance, confidence and access to vaccine information and services. It is expected that social safeguards and do-no-harm principles will underpin engagement at the community level.

4. Monitoring & reporting on vaccine access

VAHSI activities will be supported to integrate GEDSI across process and outcome indicators in monitoring, evaluation and learning frameworks (MELFs), ensuring a line of sight back to GEDSI related indicators in the VAHSI Performance Assessment Framework (PAF).

Where activities relate to vaccine coverage, partners will be encouraged to disaggregate their results by target populations, sex (minimum), age, co-morbidity, disability and other socio-demographic factors (where data allow); where activities relate to community engagement disaggregation by sex, age, disability and other socio-demographic factors (where data allow) will be encouraged.

To better understand acceptability of and access to vaccine programs amongst various groups, qualitative data and reporting on GEDSI related processes and outcomes will be sought from partners and through other mechanisms where necessary (e.g. through proactive monitoring pieces and/or seeking relevant anecdotal evidence). Where feasible, county-level monitoring and evaluation mechanisms will be used to assist with monitoring national implementation outcomes and to provide information on GEDSI related issues to inform partner policy dialogue. Reporting and learning will reflect analysis of GEDSI outcomes. Partners will additionally need to report changes on the status of social safeguarding risks.

5. Workforce development

Where opportunities present, we will encourage partners to ensure relevant trainings include content on the barriers that groups at increased risk of exclusion and disadvantage face in

accessing vaccination information and services. We will also encourage trainings and capacity building activities to be gender-equitable and disability-inclusive.

Annex 12: Accessibility description of figures

FIGURE 1

Figure 1 contains a depiction of the VAHSI Program Logic. The VAHSI Program Logic contains the following elements:

The **overarching objective**: To confirm Australia as a valued partner to countries in the Pacific and Southeast Asia by supporting their safe and effective roll outs so that their economies can reopen, contributing to economic recovery, national wellbeing and regional stability.

The overarching objective sits above the **overarching end-of-investment outcome**: Australia has helped targeted partner countries maximise immunisation coverage to prevent disease and allow a safe return to a development trajectory needed for economic and social recovery.

Beneath the overarching end-of-investment outcome sit the inputs, activities/outputs, intermediate outcomes by June 2022, end of program outcomes by December 2024, and goals.

The inputs include:

- Funding including co-funding of concessional lending
- Technical assistance
- Partnership with Australian and global expert agencies
- Partnerships with multilateral development agencies
- Diplomacy

The activities/outputs stemming from the inputs include:

1. Dose procurement and supply of equipment
2. Policy and regulatory support
3. Delivery support, logistics, cold chain, surveillance systems, technical support, human resources etc.
4. Community engagement
5. Workforce

The inputs and activities/outputs for the intervention component of the diagram, demarked by a light grey arrow underneath these two pillars, pointing to the right. The intermediate outcomes by June 2022, End of Program outcomes by December 2024, and Goals. This is demarcated by a darker grey arrow, also pointing to the right.

Within the program logic, the activities/outputs are posited to result in the following intermediate outcomes by June 2022:

IO 1: Australia contributes to partner governments' procurement of approved vaccine doses

IO 2: Partner governments introduce or strengthen policy and regulatory oversight of their COVID-19 and routine immunisation vaccination program

IO 3: Partner health authorities administer effective systems that enable accessible and safe national delivery of vaccines

IO 4: Partner countries implement an effective and inclusive COVID-19 vaccination/routine immunisation social mobilisation and engagement strategy

IO 5: Australia engages influentially for, and leverages investments in COVID-19 vaccination and routine immunisation programs

These intermediate outcomes are, in turn, posited to contribute to achievement of the following End of program outcomes by December 2024:

EOPO 1: Partner governments expand COVID-19 and routine immunisation vaccine coverage in a safe and timely manner

EOPO 2: Target populations access vaccination in accordance with national COVID-19 planning priorities

EOPO 3: Australian support to COVID-19 and routine immunisation vaccination programs is valued by the region.

The EOPOS are posited to contribute to achievement of the goals:

I 1: Improved prevention of COVID-19

I 2: accelerated economic and social recovery

I 3: Australia's reputation, relationships and influence enhanced across the region

I 4: Inclusive recovery that protects the most vulnerable, facilitates the meaningful participation of all and leaves no one behind

The EOPOS are further posited to contribute to achievement of the overarching end-of-investment outcome, indicated by an arrow connecting the EOPOs to the Overarching end of outcome, above.

The goals are posited to contribute to achievement of the overarching objective, indicated by an arrow connecting the goals to the overarching objective, above.

The diagram includes two feedback loops, indicated by arrows from the column containing the intermediate outcomes by June 2022 to the activities/outputs column, and from the activities/outputs to the inputs column.

FIGURE 2: Number of VAHSI COVID-19 vaccine doses supplied by month, Pacific Island Countries

2021

Country	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Fiji	120,000	200,000	241,000	300,000	0	215,000	0	0	0	351,000
Kiribati	0	0	0	0	0	0	0	500	0	500
Nauru	0	0	0	13,000	8,000	0	0	0	0	2,200
PNG	8,480	10,000	2,000	7,990	0	20,000	96,500	60,000	0	0
Samoa	0	0	0	50,000	0	0	0	0	2,000	12,000
SoL Is.	0	0	13,000	50,000	0	100,000	0	50,000	0	150,930
Tonga	0	0	0	0	9,000	10,000	0	0	0	0
Tuvalu	7,000	0	0	0	0	0	0	0	0	0
Vanuatu	0	0	0	20,000	30,000	0	20,000	30,000	30,000	0

2022

Country	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Fiji	0	0	0	0	0	0	88,920	0	91,980	0	332,000	0
Kiribati	5,850	5,850	0	0	6,600	0	0	0	0	0	0	0
Nauru	27,300	0	0	0	0	0	0	0	0	0	0	0
PNG	0	20,000	25,000	100	25,200	60000	0	0	0	0	0	0
Samoa	0	70,200	40,950	0	0	0	0	0	0	0	0	0
SoL Is.	0	116,470	0	0	0	0	0	0	0	0	0	0
Tonga	0	54,990	0	0	0	0	0	0	0	0	0	0
Tuvalu	0	0	0	0	0	0	0	0	0	0	0	0
Vanuatu	0	0	0	0	0	0	0	0	0	0	0	0

2023

Country	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Fiji	0	0	0	0	0	0
Kiribati	0	0	0	0	0	0
Nauru	0	0	0	0	0	0
PNG	0	0	0	0	0	0
Samoa	0	0	0	0	0	0
Sol. Is.	0	0	0	0	0	0
Tonga	0	0	0	2,200	0	0
Tuvalu	0	0	0	0	0	0
Vanuatu	0	0	0	0	0	0

FIGURE 3: Number of VAHSI COVID-19 vaccine doses supplied by month, Southeast Asian Countries

2021

Country	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Cambodia	0	0	0	0	0	0	0	2,350,530
Indonesia	0	0	0	0	1,000,000	1,200,000	2,400,000	1,950,000
Laos	0	0	0	0	0	0	0	100,000
Philippines	0	0	0	0	0	0	0	700,000
Thailand	0	0	0	0	0	0	0	0
Timor-Leste	70,000	105,000	103,200	300,000	0	0	200,000	0
Vietnam	0	0	0	402,800	300,000	800,000	0	2,281,100

2022

Country	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Cambodia	0	0	0	0	0	0	19,680,011	0	283,200	0	0
Indonesia	0	2,700,000	0	0	0	0	0	0	0	0	0
Laos	905,580	0	0	0	0	0	0	0	499,200	0	0
Philippines	0	1,432,080	0	0	0	0	0	0	3,000,000	2,001,600	998,400
Thailand	0	0	0	0	0	0	0	0	452,790	0	0
Timor0Leste	259,740	0	0	0	152,100	0	0	0	0	0	0
Vietnam	1,793,190	2,214,810	0	6,451,200	8,017,800	0	0	0	3,000,960	1,200,000	0

FIGURE 4: Estimate of VAHSI attributable proportion of total COVID-19 vaccine doses by region¹⁷ and year, 2021 and 2022

Figure 4 depicts the estimate of the proportion of total COVID-19 vaccine doses received in the Pacific and Southeast Asia regions in 2021 and 2022 that are attributable to VAHSI. In 2021, 46% of total doses received in the Pacific and 59% of the doses received in Southeast Asia were attributable to VAHSI. In 2022, 2% of the doses received in the Pacific and 9% of the doses received in Southeast Asia were attributable to VAHSI.

¹⁷ Pacific Island countries were Fiji, Kiribati, Papua New Guinea, Nauru, Samoa, Solomon Islands, Timor-Leste, Tonga, Tuvalu, and Vanuatu. Southeast Asian countries were Cambodia, Indonesia, Laos, Philippines, Thailand, and Vietnam.

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- ^{xvii} DFAT (2021), VAHSI Strategic Investment Framework (pg 10)
- ^{xviii} [i] DFAT (2023b) Design and Monitoring, Evaluation and Learning Standards <https://www.dfat.gov.au/about-us/publications/dfat-design-monitoring-evaluation-learning-standards>
- ^{xix} DFAT (2023a) op. cit.

^{xx} DFAT (2023a) op. cit., Mathieu et al., (2021) op. cit., and DFAT (2023c) Regional Vaccine Access Placemat. Department of Foreign Affairs and Trade, Canberra.